CHAPTER 4

MEDICARE BENEFICIARY ENROLLMENT IN S/HMOs

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INTRODUCTION

This chapter examines enrollment in the S/HMOs during the first 24 months of the demonstration. It focuses on answering the question of why only one of the four S/HMO demonstration sites has been able to meet its projected enrollment during this period. According to the demonstration protocol, each S/HMO projected an enrollment of 4,000 Medicare beneficiaries including a representative group of aged Medicaid recipients (about 10% of the total). In addition, enrollees were to be representative on the basis of functional status at the time of enrollment (the enrollees were limited by HCFA to no more than 5% who were nursing home certifiable at the time of enrollment). The S/HMOs were to have achieved this enrollment level within 18 months after becoming operational. Only one S/HMO demonstration project, Medicare Plus II, sponsored by the Kaiser Permanente Northwest region, met this goal.

Three major factors related to the success and failure of S/HMO enrollment were examined: (1) structural features that shaped the S/HMO product, such as plan decisions concerning provider selection, benefit package, and premium levels; (2) the competitive market environment; and (3) the effectiveness of the S/HMOs in advertising and marketing this product once defined. Special attention was given to understanding the degree to which the demonstration sites differentiated the S/HMO concept from other available Medicare alternatives, in particular, TEFRA risk-based HMOs and competitive medical plans.

METHODOLOGY

Data on S/HMO enrollments and marketing activity were collected from the four demonstration sites. Statistical data on Medicare enrollments, benefit packages, and premiums were obtained from the S/HMOs and the TEFRA HMO competitors.[1] Qualitative data on the market environment and the effect of competition on S/HMO marketing were obtained through interviews with representatives of 21 competing HMOs with TEFRA risk contracts. Interviews were also conducted with selected representatives of HMOs with cost contracts, insurance companies with dominant positions in the Medicare supplemental insurance market, multi-specialty medical group practices, and seniors organizations.

S/HMO officials at each S/HMO project were interviewed on three different occasions between January and December 1986. These officials included: the S/HMO executive directors and key administrative staff, the S/HMO marketing directors, S/HMO board members, and selected current and former S/HMO staff. Interviews focused on understanding the relationship between organizational goals and strategies and marketing activities.

S/HMO SPONSORSHIP

The S/HMO demonstrations were new organizational entities formed by existing organizations. In proposing potential demonstration sites to HCFA,

Brandeis University wanted to test the relative capacities of prepaid health plans versus long term care providers in implementing the S/HMO concept.

Two long term care organizations, neither of which had experience in administering a prepaid health plan, were selected. Elderplan, Inc., was sponsored by the Metropolitan Jewish Geriatric Center (MJGC), a nonprofit organization that owned two nursing homes and operated a variety of community-based long term care services in Brooklyn. MJGC's experience dated from 1907.[2] The second long term care site was SCAN Health Plan (SHP), sponsored by the Senior Care Action Network (SCAN), a nonprofit long term care organization established in 1978 to provide long term care services to the elderly in Long Beach, California.[3]

The third S/HMO demonstration, Medicare Plus II, was sponsored by the Kaiser Permanente Northwest Region (KP), a federally qualified HMO of 286,000 members begun in 1946. KP Northwest, located in Portland, had extensive experience in providing acute care health services to Medicare beneficiaries through cost and risk-based contracts.[4] This organization had only limited experience in providing long term care services, primarily incidental to episodes of acute care illness.

The fourth S/HMO, Seniors Plus, was sponsored by a partnership of an established HMO, Group Health, Inc., and a human services provider with substantial involvement in long term care, the Ebenezer Society.[5] Begun in 1957, Group Health, Inc. was a Federally-qualified HMO with 210,000 members and was the first prepaid health plan in the Twin Cities. A consortium of Lutheran churches established Ebenezer in 1917.

Each of these plans had a period for planning after they were selected as demonstration sites by the Health Care Financing Administration and Brandeis University in 1982. Although the sites experienced a period of delay during 1984, the S/HMOs became operational in January-March, 1985, and began marketing and enrollment activities.

ENROLLMENT AND DISENROLLMENT PATTERNS

Figure 1 shows the monthly S/HMO enrollments through April 1987. Table 1 provides the quarterly enrollment and disenrollment statistics for the first 24 months discussed in this section.

While each of the demonstration sites has shown progressive growth, only KP's Medicare Plus II met its minimum enrollment target of 4,000 members within the first 18 months (Spring 1986). Approximately 60 percent of this membership (2,400) had converted from previous Kaiser Health Plan Medicare cost contract membership, and the balance were new Kaiser members or new Kaiser retirees.

Seniors Plus was the least successful in meeting its overall membership target, having 1,688 members after 24 months; approximately 75 percent of this S/HMO's enrollees converted from Group Health's TEFRA risk and cost contracts.

FIGURE 1

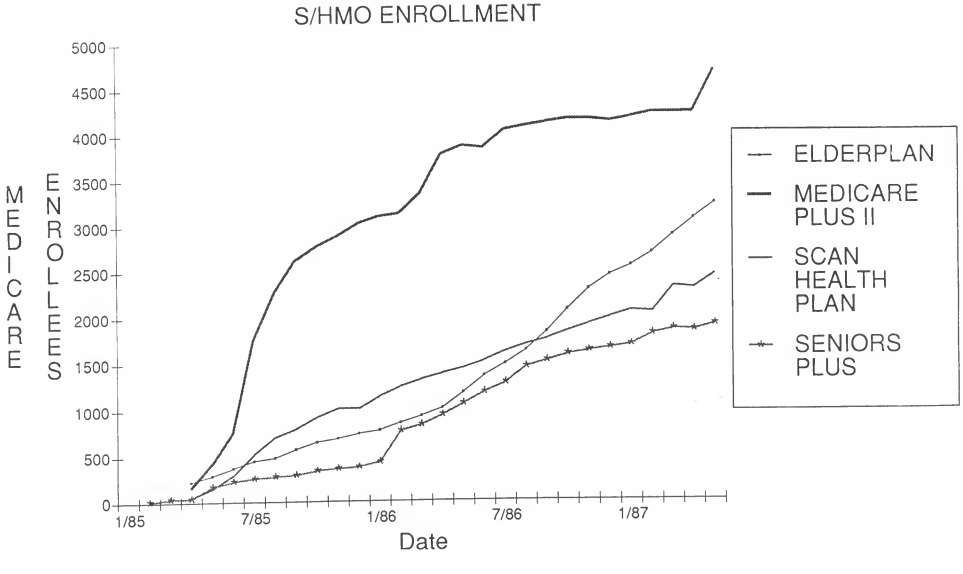

S/HMO ENROLLMENT
MEDICARE ENROLLEES
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
1/85
7/85
1/86
7/86
1/87
Date
ELDERPLAN
MEDICARE PLUS II
SCAN HEALTH PLAN
SENIORS PLUS

Table 1

CUMULATIVE AND NET S/HMO ENROLLMENT AND DISENROLLMENT BY QUARTER IN 1985 AND 1986

	1985				1986			
	1 Jan-Mar	2 Apr-Jun	3 Jul-Sep	4 Oct-Dec	5 Jan-Mar	6 Apr-Jun	7 Jul-Sep	8 Oct-Dec
Elderplan[a]								
Enrollments								
Medicare New	301	342	177	151	277	542	643	562
Medicaid New	0	4	49	1	1	2	16	36
Total Cumulative	244	596	680	806	1,048	1,544	2,121	2,642
Disenrollments								
Medicare	57	136	26	33	46	82	74	127
Medicaid	0	0	0	3	2	0	3	3
Deaths	(1)	(7)	(5)	(7)	(7)	(12)	(17)	(28)
Rate[b]	23.4%	22.8%	3.8%	4.5%	4.6%	5.3%	3.6%	5.3%
Net Enrollment[c]	244	454	654	770	1,000	1,462	2,044	2,502
Medicare Plus II								
Enrollments								
Medicare New	76	809	531	244	129	188	124	128
HMO Conversions New	97	803	528	119	629	154	60	13
Medicaid New	0	0	0	50	6	48	12	2
Total Cumulative	173	1,785	2,844	3,257	4,021	4,411	4,607	4,750
Disenrollments								
Medicare	0	5	17	29	50	51	43	43
Medicaid	0	0	0	1	3	1	2	6
Deaths	0	(0)	(16)	(20)	(34)	(35)	(43)	(42)
Rate[b]	0%	0.3%	0.6%	0.9%	1.3%	1.2%	1.0%	1.0%
Net Enrollment[c]	173	1,780	2,806	3,189	3,846	4,149	4,256	4,300
SCAN Health Plan (SHP)								
Enrollments								
Medicare New	62	449	404	236	292	296	281	251
Medicaid New	0	24	22	54	39	23	35	68
Total Cumulative	62	555	952	1,207	1,474	1,705	2,022	2,241
Disenrollments								
Medicare	0	6	28	60	76	67	83	77
Medicaid	0	1	4	3	11	10	13	22
Deaths	(0)	(1)	(7)	(4)	(10)	(15)	(17)	(22)
Rate[b]	0%	1.3%	3.4%	5.2%	5.9%	4.5%	4.7%	4.2%
Net Enrollment[c]	62	527	920	1,142	1,383	1,624	1,844	2,061
Seniors Plus								
Enrollments								
Medicare New	23	20	28	36	91	88	117	47
HMO Conversions New	26	198	60	58	419	283	226	94
Medicaid New	0	0	0	7	19	4	1	0
Total Cumulative	49	267	348	441	961	1,319	1,632	1,732
Disenrollments								
Medicare	0	7	8	7	17	29	38	43
Medicaid	0	0	0	1	0	2	2	1
Deaths	(0)	(1)	(1)	(4)	(6)	(13)	(7)	(14)
Rate[b]	0%	2.6%	2.3%	1.8%	1.8%	2.4%	2.5%	2.5%
Net Enrollment[c]	49	260	340	433	944	1,288	1,591	1,688

Source: Unpublished data from S/HMO projects.

[a] Elderplan included its cancellations and withdrawals in its statistics during quarters 1 and 2.

[b] The disenrollment rate was calculated by dividing the total number of disenrollees by total cumulative enrollment. Disenrollments due to death were included in the Medicare and Medicaid disenrollment figures.

[c] Net enrollment totals were calculated by subtracting total disenrollments from the total cumulative enrollment.

Its enrollment has continued to grow slowly and steadily after the first 24 months.

Elderplan had a slow enrollment pattern during the first 12 months of operation, with only 770 members. Since then, enrollment showed a steady increase to 2,502 at the end of the 24 months. Since Elderplan had no prior contractual relationship with the Medicare program, all these Medicare beneficiaries were new enrollees. After the first 24 months, Elderplan had an impressive growth in enrollment meeting its target at the end of 1987.

The SCAN Health Plan (SHP) pattern of enrollment also showed slow growth. After 12 months, SCAN's net enrollment was 1,142. By the end of 24 months, enrollment had increased to 2,061. Like Elderplan, SHP had no previous Medicare HMO members, so all of these were new health plan enrollees.

Each of the S/HMOs planned to enroll both Medicare and Medicaid members in numbers proportionately representative of eligible individuals in the total aged population (see Table 1). While Kaiser had a target of 500 Medicaid members, only 22 percent of the target was achieved (i.e., 108 dually eligible persons enrolled). Similarly low Medicaid enrollments were experienced at the other sites during the first 24 months: Elderplan, 517 projected, 106 enrolled; Seniors Plus, 650 projected, 22 enrolled; SHP, 800 projected, 221 enrolled.

One factor contributing to enrollment levels was the number of plan members who disenroll. The two established HMOs had notably low disenrollment rates: Kaiser Medicare Plus II had about 1 percent or less per quarter; and Seniors Plus, about 2.5 percent per quarter.

The new HMOs, in contrast, had substantially higher rates of disenrollment. SHP had disenrollment rates of about 5 percent per quarter. When voluntary disenrollments per quarter, however, were compared to new enrollments, the rates were high (e.g., 25-30% in 1986). According to SHP, its disenrollments were due to a variety of causes. Among these were movement out of the SHP service area, death, and switching to other HMOs. This latter change was reported by disenrollees to be the result of member dissatisfaction with the appointment system, physician services, physician referrals, the lock-in requirements, and the premium costs.

Elderplan also experienced some problems retaining its members. During its first two quarters, Elderplan disenrollment was 23 percent of cumulative enrollment, dropping to 4-5 percent during the two-year period. Disenrollment rates, however, were 12-23 percent of the new enrollees (see Table 1). Elderplan reported having about 85 percent of new enrollments cancel and withdraw within the first month of membership (not reported on table). Initial disenrollment stemmed, in part, from individuals who did not understand the lock-in provisions and technically should not have been enrolled. Disenrollment rates were also related to Elderplan problems in educating beneficiaries about the plan's "lock-in" feature and the difficulty enrollees had gaining timely physician appointments.

THE IMPACT ON ENROLLMENT OF S/HMO STRUCTURAL CHARACTERISTICS

Numerous decisions made by Brandeis University, the sites, and the Health Care Financing Administration in shaping the demonstration influenced the success of the S/HMOs in enrolling Medicare beneficiaries. These formative considerations included:

- The experience and reputation of demonstration sponsors in providing prepaid health care and long term care services;
- The selection of health and long term care providers who would provide S/HMO benefits;
- The formulation of the S/HMO benefit package and premium structure; and
- The selection of the market area in which to offer the S/HMO program.

SPONSORSHIP AND EXPERIENCE

At the outset of the demonstration — with the exception of SCAN, which did not have an exceptionally long history — the reputation of the S/HMO sponsors might have been predicted to represent a potentially effective marketing asset, principally name recognition and proven records of performance. This proved to be the case only for Kaiser.

At SHP, Elderplan, and Seniors Plus, sponsorship by a long term care provider may have had a negative impact on enrollment. While long term care organizational sponsorship may positively influence marketing the S/HMO to the frail elderly, many community informants believed that visible long term care sponsorship may have negatively affected the perceptions of unimpaired Medicare beneficiaries, who identified the S/HMO demonstrations with chronic illness, nursing homes, and dependency.

SELECTION OF HEALTH CARE PROVIDERS

At three of the S/HMO demonstrations, selection of physician health care providers and the way in which acute care delivery systems were configured influenced enrollment success. The selection of long term care providers appeared to have had no effect on S/HMO enrollment success.

Elderplan elected to use a staff model to provide primary care to its enrollees. This decision limited the physician choice of potential enrollees in a manner that many Medicare beneficiaries in Brooklyn may have found unattractive. New Elderplan members were required to give up the relationship with their existing physician(s) and to use only those physicians at Elderplan. While Elderplan recognized the potential marketing problems associated with a small staff model HMO for primary care services, the decision was made to use this model as a means of achieving greater control over utilization and expenditures.

Until recently, New Yorkers have had limited experience with the HMO concept, with the exception of the large staff model HMO, the Health Insurance

Plan of Greater New York (i.e., the 900,000-member HIP). For primary care, they generally relied on fee-for-service medical specialists, often associated with prestigious teaching hospitals. Large, multi-specialty group practices characteristic of health care delivery in Southern California or the Twin Cities were limited in the New York City area.

Elderplan's physician group, Geriatric Medicine Associates (GMA), was incorporated by a physician affiliated with Cornell University Medical School to provide medical services exclusively to Elderplan's enrollees.[6] At the beginning of the demonstration, GMA had only three physicians in a single clinic location which decreased to two physicians in spring 1986. During the first 24 months, Elderplan also experienced high physician turnover (all but one of the original physicians left).

Directly related to these initial problems, the plan reported many complaints relative to access to physicians, long waiting periods for appointments, and dissatisfaction with physician services. By fall 1986, Elderplan had 4 physicians and the enrollee complaints about access were somewhat reduced. Elderplan did not add a second clinic site until 1987. These problems may have had a negative effect on marketing and were apparently related to the disenrollments.

While the affiliation of GMA with Cornell University Medical School may have been a potential asset in marketing to reputation-conscious New Yorkers, the initial exclusion of local primary care physicians from participating in the S/HMO demonstration appears to have isolated Elderplan from its immediate physician community. At the very least, it severely limited, if not precluded any role of local physicians in assisting Elderplan to recruit new members. The consensus of health care industry, consumer, and union representatives interviewed was that Elderplan's model (which required relinquishing ties to an individual specialist to join a prepaid health plan where choice of primary care physician was restricted to a small physician staff) was not well accepted by Brooklyn's elderly population.

Elderplan's selection of its primary health care delivery system was not the only provider-related factor influencing enrollment. Because of its location, its reputation for high quality care, and its identification with the Jewish community, Elderplan's acute care hospital of choice was Maimonides Medical Center. While Elderplan went to great effort to reach an agreement with Maimonides, it was unable to reach one. The Maimonides management and physician staff had historically opposed hospital association with HMOs, especially staff and group-model HMOs. Maimonides' denied admitting privileges to GMA physicians during the first 24 months of the demonstration. Until January 1987, Elderplan physicians had consulting privileges only and had to work through specialty physicians with admitting privileges at Maimonides.

Because of this problem and the fact that Maimonides hospital had high occupancy rates, Elderplan had to seek another hospital for its plan members. Brooklyn-Caledonian Hospital accepted this role, and was willing to provide

full admitting privileges to GMA physicians and offered a substantial discount on per diem rates to Elderplan. Unfortunately for Elderplan, this hospital was located at the edge of the Elderplan service area in what was described as a high-crime neighborhood. Further complicating matters, the hospital's patient mix (i.e., a high proportion of its beds were occupied by low-income black and Hispanic Medicaid patients) was said to have given this hospital a poorer reputation among the primarily white middle-class Jewish and Italian seniors that made up Elderplan's market.

In an attempt to help alleviate these problems and to increase market penetration in the Bay Ridge area, Elderplan contracted with Lutheran Medical Center in February 1986. This hospital, located in the western portion of the Elderplan service area, served the white ethnic groups such as Italian, Scandinavian, and Irish populations living in the Bay Ridge section of Brooklyn. Lutheran's management orientation toward experimenting with prepaid health care delivery (e.g., the physicians having formed their own independent practice association (IPA); hospital contracts with new HMOs; and a Robert Wood Johnson Foundation grant for Health Care Plus, a prepaid plan for Medicaid members), a lower occupancy rate than its competition (80%), and its desire to provide expanded services to seniors through its community care program (CCO) led this hospital to work with Elderplan. While Lutheran signed a hospital affiliation agreement with Elderplan, its prepaid activities and senior programs (including the CCO program with case management, drug discounts, and home health services) were in competition with Elderplan and Lutheran's physician group practice opposed the hospital arrangement with Elderplan.

During the first year of this agreement, Elderplan had few admissions at either Lutheran or Brooklyn-Caledonian, and Elderplan physicians and patients continued to prefer to use Maimonides where they could only be admitted by physicians on the staff of Maimonides through GMA specialist referrals. Although Elderplan hoped that the Lutheran affiliation would improve enrollment, it may have added little to Elderplan's marketability.

S/HMO-hospital relationships also contributed to the difficulties in marketing SCAN Health Plan (SHP). In contrast to the antagonistic relationship between Maimonides and Elderplan, the relationship between SHP and its financial supporter, St. Mary Medical Center, may have been too close.

St. Mary provided grants of $300,000 to SCAN, SHP's parent corporation, and other support to the organization after it was established in 1978. In bidding to be a hospital provider to SHP, St. Mary's and another other local community hospital (Memorial Hospital of Long Beach) agreed to contribute a $1 million line of credit to establish the S/HMO. While not wholly related to previous financial support and St. Mary's relationship with SCAN, SHP considered the St. Mary offer superior and decided to use St. Mary's exclusively for acute care services on a risk contract basis. While SHP recognized the potential drawbacks of an exclusive arrangement, this was necessary to obtain the loan from St. Mary and was also expected to give the project greater control over utilization and expenditures.

SHP's exclusive use of St. Mary may have influenced the plan's marketability according to community leaders and providers interviewed. While the St. Mary association with several medical schools brought it a reputation for high quality care, it was located in a relatively poor neighborhood compared to Memorial Hospital of Long Beach and Long Beach Community Hospital. The long history St. Mary had of caring for the Long Beach indigent population may have further contributed to creating a negative image of SHP among potential enrollees with higher incomes. Its Catholic affiliation was also, at best, a neutral feature among non-Catholic seniors. Although its geographical area had a high concentration of elderly, St. Mary was generally not the first hospital of choice for seniors according to SCAN's own initial marketing survey and its hospital occupancy rates were lower than those of its two competitors.

Another problem was the inability of SHP to reach a contractual arrangement as it had initially planned with the Harriman Jones Clinic, a well-respected physician group practice in Long Beach. In the demonstration's developmental phase, Harriman Jones had agreed to serve as SHP's physician provider. With 60 full-time physicians, many contract specialists, established relationships with three HMOs, four preferred provider organizations (PPOs), and 100 area employers, Harriman Jones had extensive prepaid health plan experience and was philosophically committed to the S/HMO concept. Disagreements between St. Mary and Harriman Jones over hospital and physician relationships (unrelated to the S/HMO project) led Harriman Jones to cancel its affiliation with St. Mary in late 1984. St. Mary subsequently established its own independent physician group practice, Physicians of Greater Long Beach (PGLB).

After this development, SHP and Harriman Jones had a disagreement over the physician capitation rates and risk arrangements being offered by SHP.[7] Because Harriman Jones refused to accept a lower capitation rate than had originally been negotiated, SHP decided to enter into an exclusive contract with PGLB, which was willing to accept lower capitation rates. IPA models were considered generally attractive to seniors because of greater freedom of physician choice, so that selection of PGLB was considered by SHP to have important marketing advantages. According to some community leaders and providers interviewed, however, the decision to use PGLB may have also had some negative affects on SHP marketing. PGLB offered limited numbers of primary care physicians (20-22 within a total of 150 physicians). Older persons not already using these physicians had to change doctors in order to join SHP. In addition, the new physician group had no established service record or reputation among seniors that could be utilized in marketing SHP.

SHP's exclusive relationship with PGLB and St. Mary stood in contrast to the service delivery system options made available to Medicare beneficiaries by SHP's competition. For example, in the Los Angeles area, PacifiCare used 22 physician groups, including Harriman Jones. Maxicare had 31 physician groups consisting of over 500 physicians, affiliated with 11 hospitals. SHP's primary competition in the Long Beach market, Family Health Plan (FHP),

although a staff model, provided its enrollees with a choice of four physician groups. Moreover, both major competing hospitals in the area were marketing their own services to the elderly on a membership basis, including nursing home, respiratory therapy, rehabilitation, and home-health services. One example, Elder Med, a case management program at Long Beach Community Hospital, had many duplicate services to the S/HMO. While these hospital options were not HMOs, they provided competition for SHP in marketing its provider services, and may have led to confusion for seniors over the difference between non-HMO and HMO benefits.

Physicians can play a critical role in marketing a prepaid health plan like the S/HMO to Medicare beneficiaries by encouraging them to enroll in HMOs where the physicians are affiliated. In the case of SHP, PGLB physicians may have helped with marketing where freedom of choice was an issue. It was reported, however, that some PGLB physicians were extremely dissatisfied with the capitation rate paid by SHP. These physicians were reported to have advised their patients not to join SHP and to have lobbied actively against the demonstration. It was not until September 1985, when primary care physician capitation rates were renegotiated, that physician satisfaction began to improve. However, even with increases in reimbursement, many PGLB physicians continued not to support SHP, and their attitudes were reported by the SHMO to have a negative effect on marketing during the first 24 months. Dissatisfaction with physician was a factor in some disenrollment from SHP.

A negative impact on S/HMO enrollment of an actual or perceived limitation in provider choice may have occurred at Seniors Plus. Group Health, Inc., the HMO parent of Seniors Plus, was primarily a staff-model HMO which had recently added network-model clinics[8]. Seniors Plus decided to restrict enrollees' choice of physicians to these clinics (14 clinics with 200 physicians). In contrast to the TEFRA risk-contract enrollees of Group Health, Inc., S/HMO enrollees did not have access to the entire network of affiliated contract physicians. Seniors Plus reasoned that limiting access to staff physicians would increase the ability of the S/HMO to control utilization and decrease the possibility of adverse selection. Moreover, Seniors Plus enrollees received most inpatient care at two downtown Twin Cities hospitals that were primarily used by Group Health. While Seniors Plus recognized the decision to limit its providers would have some negative effects on marketing, it was willing to make this tradeoff to ensure financial viability.

The decision by Seniors Plus to limit physician and hospital access may have reinforced a widely held perception in the Twin Cities market that Group Health, Inc. is a provider of "clinic medicine," a corporate image that Group Health had invested considerable resources in trying to change. Competing HMOs emphasized their extensive choice of physicians and hospital affiliations in a manner that made physician and hospital availability at Group Health, Inc. and Seniors Plus appear restrictive. For example, one HMO advertised over 170 primary care sites, 1,000 primary care physicians, 1,400 specialists, and 20 hospitals, while another HMO advertised 3,500 physicians and 46 hospitals in the state.

Kaiser's provider structure did not appear to have presented any problems in marketing its S/HMO.[9] Kaiser advertised 300 salaried physicians at 12 clinic locations to provide acute care services. In contrast to Seniors Plus, S/HMO members at Kaiser were offered the same array of primary care services as any other Kaiser health plan member. Two Kaiser hospitals provided most inpatient care. While competing HMOs in the Portland market were built on independent practice association (IPA) arrangements that afford members maximum flexibility in choosing physicians, these plans were only beginning to emerge during the initial S/HMO enrollment period. This competition did not yet have Kaiser's size or its established, positive community image. As health care competition increased in Portland over the 24-month period, these newer prepaid providers began to use their large provider networks to distinguish themselves from the Kaiser model. While this may affect future enrollment success for Medicare Plus II, it came too late to be an adverse factor in the initial enrollment phase.

MARKET AREA

Table 2 presents population statistics on the market areas selected by the S/HMOs. Each S/HMO site had an initial target area of 80,000-108,000 potential members. Within these areas, the Medicaid-eligible population was estimated at between 6 and 16 percent. The S/HMOs initially considered that this population base would be adequate for meeting their enrollment targets.[10]

Two sites later expanded their market areas, after enrollment targets were not achieved. Elderplan requested and received approval for HCFA to expand its original service area from 7 to 16 Brooklyn zipcodes in fall 1985 (adding another 100,000 Medicare beneficiaries to its population base). Seniors Plus originally targeted only Hennepin County (i.e., Minneapolis and suburbs). It also expanded its market area to seven counties in the Twin Cities metropolitan area in fall 1985 to add another 100,000 population to its area.

Both sites found the expansion of their market areas to be useful, although Elderplan continued to draw most of its enrollees (67%) from its initial geographical area, near its one physician clinic site. Seniors Plus continued to enroll 63 percent of its members from Hennepin County, but found that expansion increased its group enrollment. Expanding the geographical area without expanding the available provider network described earlier, however, appeared to limit the potential positive marketing effect that the expansion might otherwise have had.

Interviews with competing HMOs and other community representatives strongly indicated that restricting market areas adversely affected initial S/HMO enrollments because: (1) the target population was limited; (2) electronic media and broad circulation print media could be not be used effectively in plan advertising; and (3) the S/HMO would not appear as attractive to employers who contribute to the health benefits of their

Table 2

AREA POPULATION STATISTICS AND ESTIMATED HMO PENETRATION RATES IN 1985

Service Area[1]	Total Population	Percentage Pop. 65+ (Number)	Percentage Medicaid Eligible (Number)	HMO Medicare Penetration Rate (Number of Enrollees)[2]
Brooklyn				
New York/New Jersey metropolitan area	8,465,821[a]	13.5% (1,143,251)[b]	- -	6.9% (79,171)[c,d]
7 zipcode original service area	490,481[e]	19.8% (97,182)[e]	12.1%[5][f] (11,798)	- -
16 zipcode area	1,016,596[e]	19.4% (197,273)[e]	12.7%[5][f] (24,955)	- -
Long Beach				
30 zipcode service area	1,135,909[e]	9.5% (107,942)[e]	16.0% (17,239)	- -
Los Angeles metropolitan area	7,941,575[g]	10.7% (849,178)[g]	19.6% (156,351)	23.8% (202,228)[c,d]
Portland				
Multnomah County	561,800[h]	14.2% (79,855)[h]	6.3% (4,722)[4]	- -
Portland metropolitan area	1,339,000[h,i]	11.8% (158,213)[h,i]	- -	16.4% (25,945)[c,d]
Minneapolis				
Hennepin County original service area	947,852[j]	10.8% (105,284)[k]	11.4%[f] (12,002)	- -
Minneapolis/St. Paul metropolitan area	2,118,445[j]	9.9% (209,350)[k]	12.9%[3] (14,100)	59.7% (124,977)[c,d]

Sources: [a] State of New York, Department of Commerce. Provisional 1985 County Estimates. Unpublished data. n.d.
[b] State of New York, Department of Commerce. Official Population Projections for New York State Counties: 1980-2010. Albany, NY: April 1985.
[c] InterStudy Center for Aging and Long-Term Care Improving Health and Long-Term Care for the Elderly. 1986.
[d] Institute for Health & Aging (IHA). Interviews with HMOs. San Francisco, CA: University of California, 1986.
[e] Western Economic Research Co., Inc. Summary of Key 1984 Demographic

Characteristics by Zipcode. Unpublished data. 1986. State of New York, Department of Commerce. Selected 1980 Census Data. Unpublished data, 1986.
[f] U.S. Department of Commerce. Bureau of the Census. 1980 Census of Population: General Social and Economic Characteristics, 1983.
[g] State of California, Department of Finance. Population Projections for California Counties, 1980-2020 with Age/Sex Detail to 2020, Baseline 1983. Sacramento, CA: October 1983.
[h] Center for Population Research and Census, Portland State University. Estimates of the Population by Age Groups for Oregon and Counties, July 1, 1985. Unpublished data. January 1986.
[i] State of Washington, Office of Financial Management. 1986 Population Trends for Washington State. Unpublished data. August 1986.
[j] Metropolitan Council of the Twin Cities Area. April, 1986 Population Estimates for Cities, Townships, and Counties in the Twin Cities Metropolitan Area. St. Paul, MN: Metropolitan Council, August 4, 1986.
[k] Metropolitan Council of the Twin Cities Area. Projected Population by Age and Sex, Metropolitan Area, 1985. Unpublished data. November 1, 1983.

[1] The Portland Metropolitan Area is defined as the five-county area consisting of Multnomah, Washington, Clackamas, Yamhill (all in the state of Oregon) and Clark (in the state of Washington). The Twin Cities Metropolitan Area is defined as the seven-county area consisting of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. The New York/New Jersey Metropolitan Area is defined as the eight-county area consisting of Putnam, Westchester, Rockland, Bronx, Queens, New York, Kings and Richmond. The Los Angeles Metropolitan Area is defined here as Los Angeles County.

[2] The Medicare HMO enrollment figures include estimates of the total cost and risk contract enrollees in an area for June 1986. In New York, almost all enrollees are in the HMO with a cost contract. In Los Angeles, only 27% of total Medicare enrollees are in HMOs with cost contracts. See Tables 2-5 for specific HMO enrollment statistics.

[3] Uses 1985 data for Medicaid aged recipients divided by 1985 aged population data. The 1985 Medicaid data for aged recipients for Hennepin County and Dakota County where marketing is being done for the aged.

[4] Multnomah County has 1,906 aged Medicaid individuals eligible for services in the Adult and Family Services Division (that has a contract with the Kaiser S/HMO) and 2,816 aged individuals eligible for Medicaid long term care services in the Division of Social Services in October 1986.

[5] Percentages pertain to 1980 statistics. Numbers refer to 1984, 1985, or 1986 population figures, estimated from 1980 percentages.

retirees residing throughout the metropolitan area. S/HMO prepaid health plan competitors did not restrict their marketing areas. Especially in the highly competitive Southern California and Twin Cities markets, the S/HMOs competed with many HMOs whose growth objectives had evolved beyond their metropolitan areas to encompass regional or national goals. Plans with national geographic coverage were reported to be particularly attractive to retirees who spend limited portions of the year in favorable climates outside their communities. Restricting enrollment in the S/HMO to a sub-area of the metropolitan area ran directly counter to this trend.

Kaiser's decision to market Medicare Plus II only in Multnomah County and to market its Medicare Plus I TEFRA risk option in the other six Portland metropolitan counties had no adverse effect on total enrollment. But this limited geographic area did appear to limit Kaiser's ability to enroll members from employer groups.

THE COMPETITIVE ENVIRONMENT

Extensive competition among prepaid health plans to enroll Medicare beneficiaries severely disadvantaged two of the four S/HMO demonstrations, SHP and Seniors Plus. The emerging competition in Portland was increasing but did not negatively affect Kaiser.

Prepaid health care was not new to the four S/HMO market areas. Each area had a large prepaid health plan predating the Medicare program: Health Insurance Plan (HIP) in New York; Kaiser Permanente in Portland and Los Angeles; and Group Health, Inc. in Minneapolis-St. Paul. By spring 1986, New York had a Medicare HMO penetration rate of about 7 percent; Portland, 16 percent; Los Angeles, 24 percent; and the Twin Cities, 60 percent (Table 2). Figures 2 through 5 show the competing HMOs and the Medicare enrollment in each of the S/HMO market areas. For details, see Appendix A. Based on these penetration rates of Medicare enrollment and the number of competing HMOs, these markets can be categorized as follows: New York, "newly competitive"; Portland, "emerging competitive"; and Los Angeles and Minneapolis-St. Paul, "mature competitive." (See Harrington, Newcomer, and Moore, 1987, for discussion of the market competition).

Elderplan in one sense competed against HIP; against the public's generally negative concept of prepaid health care and the HIP community image developed over 40 years. HIP had approximately 900,000 members at the end of 1985, 8.7 percent of whom were Medicare beneficiaries enrolled in its Health Care Prepayment Plan (HCPP) Medicare contract and 20,444 of its Brooklyn Medicare members. Practically, however, neither HIP nor the prepaid health plans entering New York City in 1985-1986 marketed to seniors during the first 24 months of the S/HMO demonstration. Thus, Elderplan's principal market competition was Medicare supplemental insurance offered by Empire Blue Cross-Blue Shield and other private insurance companies.

The New York City market became more competitive when investor-owned HMOs entered the market in spring 1986. Competing HMOs reportedly invested some

FIGURE 2

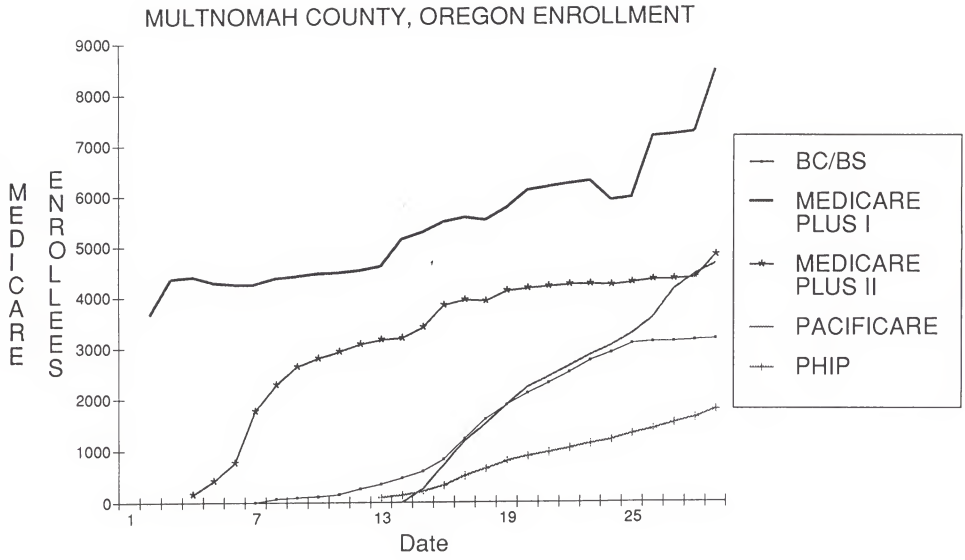

MULTNOMAH COUNTY, OREGON ENROLLMENT
MEDICARE ENROLLEES
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
1
7
13
19
25
Date
BC/BS
MEDICARE PLUS I
MEDICARE PLUS II
PACIFICARE
PHIP

FIGURE 3

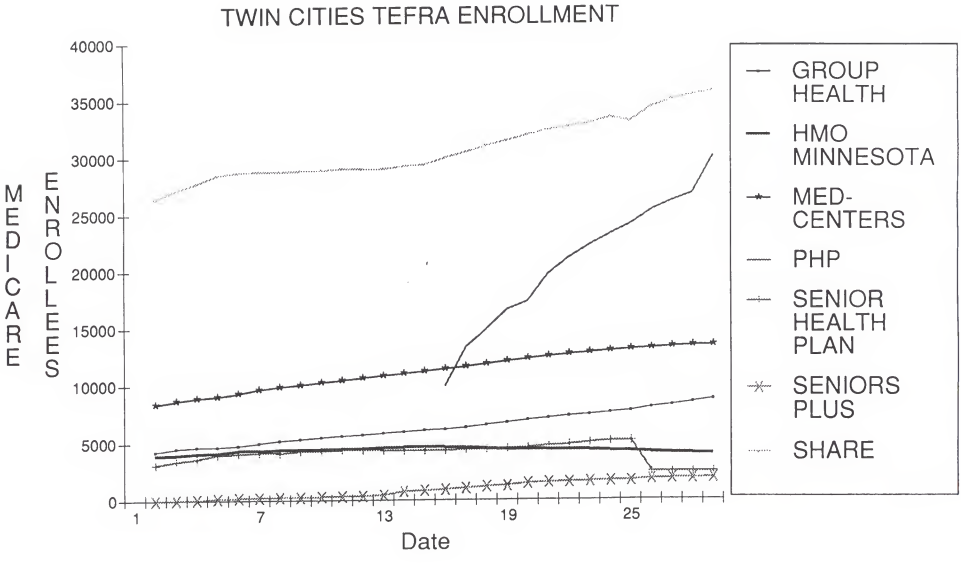

TWIN CITIES TEFRA ENROLLMENT
MEDICARE ENROLLEES
40000
35000
30000
25000
20000
15000
10000
5000
0
1
7
13
19
25
Date
GROUP HEALTH
HMO MINNESOTA
MED-CENTERS
PHP
SENIOR HEALTH PLAN
SENIORS PLUS
SHARE

FIGURE 4

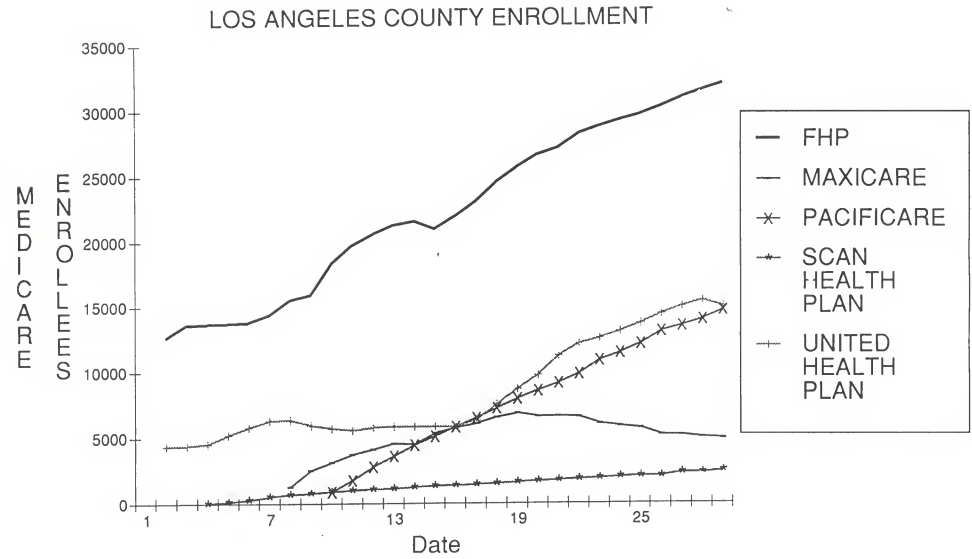
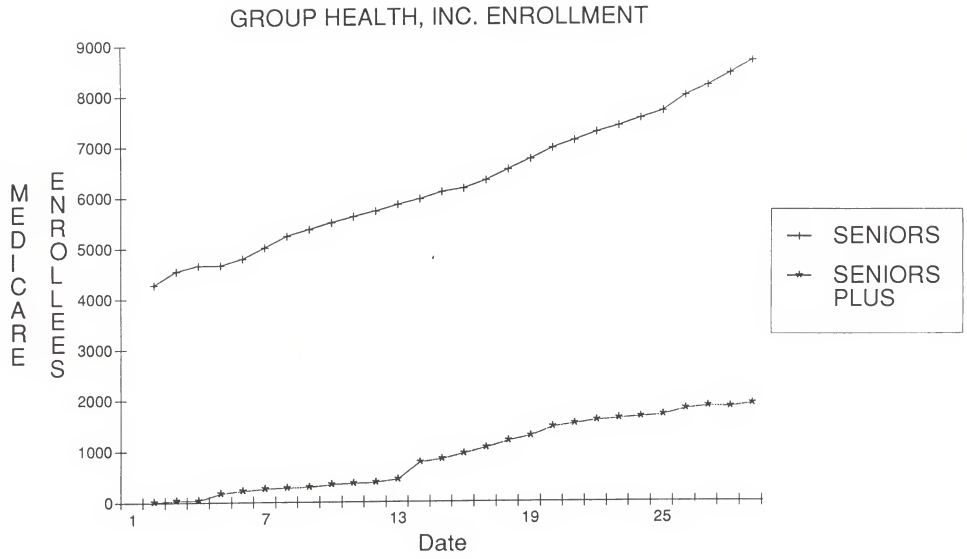

LOS ANGELES COUNTY ENROLLMENT
MEDICARE ENROLLEES
35000
30000
25000
20000
15000
10000
5000
0
1
7
13
19
25
Date
FHP
MAXICARE
PACIFICARE
SCAN HEALTH PLAN
UNITED HEALTH PLAN

FIGURE 5


GROUP HEALTH, INC. ENROLLMENT
MEDICARE ENROLLEES
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
1
7
13
19
25
Date
SENIORS
SENIORS PLUS

$10 million in their initial advertising compaigns (Freudenheim, 1987). The results of marketing to the non-Medicare population in 1986 were fewer than 100,000 new subscribers, according to four HMOs (Freudenheim, 1987).

In Portland, the dominant position of Kaiser, both in the under-65 group and Medicare markets, was being tested by emerging competitors, none of which threatened KP's market leadership in 1985 and 1986. Figure 2 shows that KP's Medicare Plus I had a high enrollment of Medicare members in 1985 because of its previous TEFRA demonstration project and doubled its enrollment over the period. [11] When Kaiser's Medicare Plus II began marketing, there was little competition in the area. The early entry of KP into the market with both its TEFRA and its S/HMO was clearly an important advantage in market success. The other new prepaid plans began to grow in 1986, however, and altogether reached about 8,000 total members (see Appendix Table A-1 for details).

It was in Los Angeles and the Twin Cities that competition among prepaid health plans to enroll Medicare beneficiaries was most dramatic, and such competitive behavior adversely affected the potential of S/HMO demonstrations to achieve enrollment targets.

While no empirical research existed that measured the penetration rate at which a health care market can be considered saturated (i.e., new market entrants will not be able to attract members because most persons who would select an HMO option have already done so), the market penetration was extremely high in those two areas. At the outset of the demonstration, SHP and Seniors Plus faced highly competitive markets when beneficiaries who remained in fee-for-service had already been heavily exposed to HMO marketing and had decided not to join a prepaid health plan. As an alternative market segment for the S/HMOs, existing Medicare HMO members had established plan loyalties that were difficult to sever.

Most of the TEFRA contractors in the Twin Cities participated in Federal Medicare capitation or competition demonstration projects from 1980 until TEFRA's implementation in April 1985. In Minneapolis, prior to the initiation of Seniors Plus marketing, an estimated 50,000 Medicare beneficiaries had enrolled in Medicare prepaid health plan (PHP) alternatives (Iversen, Polich, and Dahl, 1985b; Institute for Health & Aging, 1985 estimates in Appendix Table A-5). A substantial portion of this enrollment occurred during 1984, prior to the introduction of Seniors Plus. As of June 1986, seven Twin Cities HMOs had received or had applied for Medicare risk contracts. Figure 3 shows the dominance that SHARE had over the market and the rapid conversion of PHP members from its cost to its TEFRA HMO during the 1985-87 period. MedCenters plan remained third with slower growth. Group Health Seniors and Seniors Plus had a significantly lower enrollment and growth in enrollment.

In Los Angeles, SHP's primary competitor, Family Health Plan, Inc. (FHP) had also been a Medicare HMO demonstration site, commencing risk-based Medicare contracting in 1983 (see Figure 4). Aggressively marketing its Medicare options using television and direct mail while offering standard Medicare coverage at no cost to the beneficiary, FHP enrolled 10,000 Medicare

beneficiaries during its first three months in operation. Before SHP began initiative, FHP had already enrolled approximately 13,000 seniors (although FHP claimed an additional 7000 at that time), a majority of whom lived in SHP's Long Beach market area (see Figure 4). Prior to the SHP marketing initiative, some 150,000 Medicare beneficiaries in the Los Angeles area were enrolled in some form of prepaid health plan arrangement (Iversen et al., 1985b; IHA 1985 estimate in Appendix Table A-4). As of June 1986, eight of the 11 Los Angeles HMOs had received or applied for Medicare risk contracts. United Health Plan and PacifiCare were the two major competitors after FHP in the area, while MaxiCare decreased its enrollment of Medicare members (Harrington, Newcomer, and Moore, 1987).

The timing of the S/HMO entry into the marketplace was also a critical factor. The initial planning and marketing activities for the S/HMO were conducted in 1983. As the S/HMOs prepared for start-up, there was a one year delay in federal approval which was not resolved by Congress until the Summer of 1984. The S/HMOs then submitted their plans for operation and were approved for start-up in early 1985. The one year delay was a serious negative factor in terms of enrollment success in the two highly competitive areas of Long Beach and Minneapolis/St. Paul. First, the delay in funding forced in the S/HMOs to layoff almost all staff that had been involved in the initial planning of the projects, and created serious morale problems for the staff. More important, the marketing conditions changed in terms of competing prices, benefits and other such factors. During that one year period of 1984, substantial numbers of elderly were enrolled in the HMO risk contract demonstration plans which later became TEFRA risk contractors in the Long Beach and the Minneapolis area, making it more difficult for SHP and Seniors Plus to attract new members.

DESIGNING BENEFIT PACKAGES AND SETTING PREMIUMS

Specifying benefit packages and setting premium levels (the amount paid by beneficiaries to the S/HMO) were two critical decisions made by the S/HMOs in the marketplace. Price and breadth of coverage are the two most easily understood criteria that Medicare beneficiaries can use to differentiate prepaid health plan options. The S/HMOs had to balance developing comprehensive benefits with a marketable premium. In order to successfully market an expanded benefit package, potential members needed to value additional services at least as highly as the additional premium needed to cover the costs of these services. This proved to be a major problem for the S/HMOs.

BENEFITS

Table 3 details the S/HMO benefit package. The S/HMO benefit package has two distinct parts. The first part consists of standard Part A and Part B Medicare coverage, augmented by medical and related services not covered by Medicare (e.g., prescription drugs, hearing aids, eyeglasses) and coverage of out-of-pocket physician and hospital deductibles and coinsurance. In this regard, S/HMO coverage was comparable to the benefit packages of many "high

Table 3

COMPARISON OF BENEFITS IN 1987

Service	Medicare Benefit	S/HMO Benefit	HMO Benefit
Acute hospital	90 days each benefit period plus 60-day lifetime reserve. $a92 deductible per spell of illness on part A benefits required. Copays noted below are 1986 figures and assume deductible has been paid. For each day between 61st and 90th day, the beneficiary pays $123. For each reserve day, the payment is $246.	Unlimited number of days for prescribed hospitalization at hospital approved by S/HMO. Covered in full.	Covered in full at approved hospitals when authorized by a member physician. Total days of coverage may be limited in some plans.
Psychiatric hospital	190 days lifetime. Copayments same as inpatient hospital.	190 days lifetime. No copays, no charges.	190 days lifetime limit. Covered in full up to a specified number of days (e.g., 60); copay of $15-$25 or more per day apply thereafter until the 190-day limit is reached.
Skilled nursing facility care meeting Medicare criteria (Rehab.)	After 3 consecutive days in hospital, transferred to SNF; first 20 days, no charge; 21st thru 100th day, $61.50/day.	No prior hospitalization requirement. No deductibles, no charges.	Generally covered in full up to 20 or 100 days, sometimes for unlimited number of days.
Physician's services	Medicare pays 80 percent of allowable charges after $75 annual deductible on Part B benefits is paid. Includes ambulatory (outpatient) surgery. Physicals and preventive care not covered.	Covers Medicare deductible and coinsurance.	Covered in full or requires copay ranging from $2 to $5 per visit depending on plan.
Mental health OP visits	80 percent of doctor charges up to $250 maximum (after $75 deductible). 80 percent of other professional charges.	Kaiser: 6 visits per year to psychiatrist; no limit to other Professionals. Other sites, 20 visits per year. Copay per visit: Kaiser, $2; Elderplan, $5; Seniors Plus, $10; SCAN, no charges.	Coverage varies by plan. Copay ranging from $2-$5 per visit for first 10 to 20 visits per year in many plans. Others offer 80 percent coverage up to a maximum of $1,000. In others members pay $10 per visit up to a maximum of $500 in services. Other variations exist.
Blood	First 3 pints not covered; then 80 percent of allowable.	Covered in full.	Covered in full.
Medical equipment and supplies	80 percent of allowable charges on durable medical	Covered in full.	Covered in full.

(Table 3 cont'd.)

Service	Medicare Benefit	S/HMO Benefit	HMO Benefit
	equipment, prosthetic devices, and supplies.		
Lab and X-ray	Part B services: 80 percent of allowable charges.	Covered in full.	Covered in full or requires copay of $2-$5.
Dentistry	80 percent of allowable charges only if it involves surgery of the jaw, setting fractures of the jaw and facial bones, treatment of oral infection, dental procedures that are integral part of medical procedures. Routine dental services not covered.	Medicare benefits covered in full -- no charges. SCAN also covers routine dental care; $50 copay for crown or bridge.	Medicare benefits covered in full or requires copay of $2-$5.
Outpatient physical therapy and speech pathology services	Part B services: 80 percent of allowable charges.	Covered in full. No charges except Kaiser, $2 regular fee.	Covered in full or requires copay of $2-$5 per visit.
Out of plan services	Emergency and nonemergency services covered anywhere in the United States; 80 percent of allowable charges.	Approved emergency services covered in full anywhere in the world. Kaiser and SCAN, no charges. Elderplan and Seniors Plus, 80 percent coverage of first $500, then same coverage as hospital and medical services described above.	Generally covers 80 percent of first $500 or $1,000 and 100 percent of remaining costs. Many plans cover 100 percent of emergency services worldwide.
Pharmacy	Not covered except injections (other than immunizations) which are administered by a physician or nurse.	Prescription drugs covered at all sites. Copay range, $1 to $2.	Coverage varies by plan. Some high option plans cover outpatient prescription drugs with copay ranging from $2 to $4.
Optometry	Only covered if related to treatment of aphakia or if part of a covered medical service.	Covered in full. Kaiser, $2 copay. Elderplan specifies one exam per year.	Covered in full or requires copay of $2-$5.
Audiometry	Not covered (except as part of post-hospital inpatient extended care services under Part A).	Covered in full. Elderplan specifies one exam per year. Kaiser, $2 copay.	Covered in full or requires copay of $2-$5.
Foot care	Routine foot care services not covered except when performed as necessary part of a covered medical service. Medicare pays 80 percent of allowable charges.	Medically necessary podiatry. Kaiser, $2 copay, other sites, no charges. Elderplan in addition provides routine foot care at $2 per visit.	Routine foot care covered in full or with copay of $2-$5 in many plans. Some plans exclude this coverage.

Table 3

COMPARISON OF BENEFITS IN 1987

Service	Medicare Benefit	S/HMO Benefit	HMO Benefit
Acute hospital	90 days each benefit period plus 60-day lifetime reserve. $492 deductible per spell of illness on part A benefits required. Copays noted below are 1986 figures and assume deductible has been paid. For each day between 61st and 90th day, the beneficiary pays $123. For each reserve day, the payment is $246.	Unlimited number of days for prescribed hospitalization at hospital approved by S/HMO. Covered in full.	Covered in full at approved hospitals when authorized by a member physician. Total days of coverage may be limited in some plans.
Psychiatric hospital	190 days lifetime. Copayments same as inpatient hospital.	190 days lifetime. No copays, no charges.	190 days lifetime limit. Covered in full up to a specified number of days (e.g., 60); copay of $15-$25 or more per day apply thereafter until the 190-day limit is reached.
Skilled nursing facility care meeting Medicare criteria (Rehab.)	After 3 consecutive days in hospital, transferred to SNF: first 20 days, no charge; 21st thru 100th day, $61.50/day.	No prior hospitalization requirement. No deductibles, no charges.	Generally covered in full up to 20 or 100 days, sometimes for unlimited number of days.
Physician's services	Medicare pays 80 percent of allowable charges after $75 annual deductible on Part B benefits is paid. Includes ambulatory (outpatient) surgery. Physicals and preventive care not covered.	Covers Medicare deductible and coinsurance.	Covered in full or requires copay ranging from $2 to $5 per visit depending on plan.
Mental health OP visits	80 percent of doctor charges up to $250 maximum (after $75 deductible). 80 percent of other professional charges.	Kaiser: 6 visits per year to psychiatrist; no limit to other Professionals. Other sites, 20 visits per year. Copay per visit: Kaiser, $2; Elderplan, $5; Seniors Plus, $10; SCAN, no charges.	Coverage varies by plan. Copay ranging from $2-$5 per visit for first 10 to 20 visits per year in many plans. Others offer 80 percent coverage up to a maximum of $1,000. In others members pay $10 per visit up to a maximum of $500 in services. Other variations exist.
Blood	First 3 pints not covered; then 80 percent of allowable.	Covered in full.	Covered in full.
Medical equipment and supplies	80 percent of allowable charges on durable medical	Covered in full.	Covered in full.

(Table 3 cont'd.) Service	Medicare Benefit	S/HMO Benefit	HMO Benefit
	equipment, prosthetic devices, and supplies.		
Lab and X-ray	Part B services: 80 percent of allowable charges.	Covered in full.	Covered in full or requires copay of $2-$5.
Dentistry	80 percent of allowable charges only if it involves surgery of the jaw, setting fractures of the jaw and facial bones, treatment of oral infection, dental procedures that are integral part of medical procedures. Routine dental services not covered.	Medicare benefits covered in full -- no charges. SCAN also covers routine dental care; $50 copay for crown or bridge.	Medicare benefits covered in full or requires copay of $2-$5.
Outpatient physical therapy and speech pathology services	Part B services: 80 percent of allowable charges.	Covered in full. No charges except Kaiser, $2 regular fee.	Covered in full or requires copay of $2-$5 per visit.
Out of plan services	Emergency and nonemergency services covered anywhere in the United States; 80 percent of allowable charges.	Approved emergency services covered in full anywhere in the world. Kaiser and SCAN, no charges. Elderplan and Seniors Plus, 80 percent coverage of first $500, then same coverage as hospital and medical services described above.	Generally covers 80 percent of first $500 or $1,000 and 100 percent of remaining costs. Many plans cover 100 percent of emergency services worldwide.
Pharmacy	Not covered except injections (other than immunizations) which are administered by a physician or nurse.	Prescription drugs covered at all sites. Copay range, $1 to $2.	Coverage varies by plan. Some high option plans cover outpatient prescription drugs with copay ranging from $2 to $4.
Optometry	Only covered if related to treatment of aphakia or if part of a covered medical service.	Covered in full. Kaiser, $2 copay. Elderplan specifies one exam per year.	Covered in full or requires copay of $2-$5.
Audiometry	Not covered (except as part of post-hospital inpatient extended care services under Part A).	Covered in full. Elderplan specifies one exam per year. Kaiser, $2 copay.	Covered in full or requires copay of $2-$5.
Foot care	Routine foot care services not covered except when performed as necessary part of a covered medical service. Medicare pays 80 percent of allowable charges.	Medically necessary podiatry. Kaiser, $2 copay, other sites, no charges. Elderplan in addition provides routine foot care at $2 per visit.	Routine foot care covered in full or with copay of $2-$5 in many plans. Some plans exclude this coverage.

(Table 3 cont'd.)

Service	Medicare Benefit	S/HMO Benefit	HMO Benefit
Eyeglasses	Not covered (except prosthetic and contact lenses which are medically necessary to restore vision provided by the crystalline lense of the eye).	Covers one pair glasses in each 24-month period. Kaiser and SCAN, no charge. Elderplan, $10 copay; Seniors Plus, 50 percent copay.	Many plans do not cover eyeglasses. Some offer eyeglasses without copay or with copay ranging from $5-$12 or at 50 percent discount.
Hearing aids	Not covered.	Covers one hearing aid in each 24-month period. (Kaiser is one every 3 years.) Copays: Elderplan, $40; SCAN, $50; Seniors Plus, 50 percent; Kaiser, $50.	Most plans exclude coverage for hearing aids. Some plans offer a discount toward purchase once every 2-5 years.
Dentures	Not covered (unless part of a "prosthesis" which is an integral part of a medical procedure that is covered).	Elderplan and SCAN cover dentures with $50 copay. Kaiser excludes dentures; Seniors Plus excludes dentures in almost all cases. SCAN also covers routine dental care. Seniors Plus covers diagnostic and preventive care. Elderplan covers erupted tooth extractions and denture repair with $15 copay.	Many plans exclude coverage for dentures. Some offer dentures with $250 copay or every 5 years with $150 copay. Other plans give a 20 percent discount toward purchase.
Home-health services	100 percent of allowable costs, skilled care criteria and homebound.	Medicare home-health covered in full. Coverage expanded beyond skilled care and homebound criteria when approved for long-term care plan. Copay $10/visit for Elderplan, 20 percent of Seniors Plus, 10 percent of Kaiser, and $5 for SCAN.	Covered in full per Medicare guidelines.
In-home support services	Not covered.	Covered with limits,* copays and renewability conditions that vary by site. Limits are as follows: SCAN, up to $7,500 annually; Eldercare, up to $6,500 per year; Kaiser, up to $12,000 annually; and Seniors Plus, $6,500 lifetime limit and a $5,000 annual limit.	Not covered.
Hospice	5 percent copay or $5 per prescription for outpatient drugs, whichever is less. 5 percent copay for	Covered in full (no copays).	Covered in full in approved programs when authorized by a member physician. Total days of care may be limited

(Table 3 cont'd.) Service	Medicare Benefit	S/HMO Benefit	HMO Benefit
	in-patient respite costs, up to a maximum of $492. All other hospice services are fully covered.		.n some plans.
Nursing home custodial	Not covered.	Covered up to a limit[a] of: Elderplan, $6,500; Kaiser, (100 days per spell of illness or $12,000 per year maximum, whichever comes first); Seniors Plus, $6,500 lifetime for nursing home care (net costs) or $5,000 annually; and SCAN, $7,500 annually. Copayment of 20 percent at Elderplan and Seniors Plus, 10 percent at Kaiser, 15 percent at SCAN.	Not covered.

SOURCE: Data modified from Table 3-1 SHMO Benefits Package Compared with Medicare Part A and Part B Coverage from Leutz, W. N. et al., Changing Health Care for an Aging Society. Lexington, MA: Lexington Books, D.C. Heath and Company, 1985, pp. 62-64. Data added from Commerce Clearing House Medicare and Medicaid Guide and interviews of SHMO and HMO officials in 1987. Chicago, IL.

[a] These limits are applied to the total cost of several different types of long term care services including institutional and community-based care.

option" TEFRA risk-based contractors.

The second set of benefits that distinguished the S/HMOs from other Medicare prepaid health plan alternatives was the coverage of chronic care services. No TEFRA HMO or CMP offered this array of chronic care benefits. The "long term care" benefits provided by TEFRA HMOs generally conformed to fee-for-service Medicare skilled nursing care and home-health coverage. Like fee-for-service Medicare programs, TEFRA HMOs do not offer community-based or institutional long term care benefits to enrollees whose need for services is associated with chronic functional impairment (e.g., care needs associated with Alzheimer's disease). Interviews with representatives of TEFRA HMOs in the S/HMO market areas revealed a reluctance to offer the type of chronic care benefits provided in the S/HMO benefit package.

S/HMO representatives and representatives of senior organizations reported that the way in which the HMOs described their Medicare skilled nursing facility and home-health benefits in plan marketing literature conveyed the impression of more long term care coverage than was actually available. For example, HMOs advertised payment in full for Medicare skilled nursing and home-health benefits, not pointing out that these benefits did not include chronic care. Thus, TEFRA HMO coverage appeared more like the chronic care benefit coverage provided by the S/HMO than it actually was.

Consumer respondents also raised the issue of the attractiveness of S/HMO chronic care benefits to seniors seeking some form of long term care insurance coverage. The S/HMO benefit was an increment toward providing chronic care benefits within a prepaid financing arrangement. At SHP, the maximum chronic care benefit for both institutional and community-based care was $7,500, renewable annually; at Medicare Plus II, the annually renewable chronic care benefit was $12,000 per year, allocated up to a maximum of $1000 per month for in-home support; at Elderplan, the annually renewable benefit was set at $6,500; at Seniors Plus, a $6,500 lifetime limit was set for chronic nursing home care (for net benefits minus the copayments), and with a $5,000 annual maximum. All plans had 10-20 percent coinsurance for their chronic care benefits. These benefits were also reported by some individuals to be substantially less than the long term care benefits available through private insurance.

From a marketing research perspective, it could be hypothesized that few older persons in good health with no functional impairments would be interested in purchasing S/HMO benefits at premium levels higher than available TEFRA HMO alternatives, especially in the absence of sophisticated selling techniques to convince these persons to purchase the S/HMO as a form of relatively limited long term care insurance. Alternatively, a question remained as to whether severely impaired older persons would perceive S/HMO benefits as sufficiently attractive to warrant additional premium investment and incurring opportunity costs (e.g., selecting a new primary care physician). For example, since custodial nursing home costs ranged between $40-150 per day and home-health care from $40-100 per visit in the S/HMO market areas, severely impaired persons could exhaust S/HMO chronic care

benefits within three months or less.

Many senior advocates interviewed described this key dilemma in marketing the S/HMO benefit package: severely impaired seniors might perceive the extent of S/HMO chronic care coverage as inadequate, whereas increasing the breadth and depth of chronic care services coverage would require premiums that might price the S/HMO out of the range of many middle-class older persons and/or attract only impaired elderly to the S/HMO. A later section of this report presents an analysis of the consumer choice decisions of S/HMO, TEFRA HMO, and fee-for-service beneficiaries in the S/HMO market areas relevant to these complex product positioning issues.

PREMIUMS

At the beginning of the demonstration, monthly premium levels were as follows: Elderplan, $29.89; Medicare Plus II, $49; Seniors Plus, $29.50; and SHP, $40. With the exception of Seniors Plus, which lowered its premium to $24.95 in March 1986, the 1986-1987 premium levels at the other sites were unchanged during the first 24 months. SHP did, however, change its premium to include a $24.95 option in 1987.

S/HMO premiums were generally not based on the estimated costs of providing plan chronic care benefits. Instead, the S/HMOs reported that the major consideration in setting their premium levels was to be price competitive with existing HMO and Medicare supplemental insurance options in their respective markets. The S/HMOs had to balance the costs of providing their benefit package with their assessment of a marketable premium. The sites did some actuarial work as well as market testing to determine a marketable balance between these two factors. The S/HMOs in competitive market areas, however, did not achieve their goals of being price competitive with respect to TEFRA HMO competition.

In each demonstration site, S/HMO premiums were less than competing comprehensive Medicare supplemental policies and greater than competing high-option Medicare HMO alternatives (except for Elderplan where none existed). The unfavorable pricing of the S/HMOs relative to their prepaid health plan competition was most pronounced in Long Beach. In Los Angeles County, four HMOs offered standard Medicare coverage with minimal coinsurance and/or deductibles at no out-of-pocket cost to beneficiaries (i.e., so-called "zero premium" plans). When these plans also offered a high option that included services that Medicare does not cover (e.g., prescription drugs, eyeglasses), competitors' premiums ranged from $20-35 per month. Thus, the high-option HMO plans in the Long Beach area were lower than the SHP premium.

Price competition was also disadvantageous to S/HMO marketing in the Twin Cities area. For example, SHARE Health Plan and Senior Health Plan offered a basic Medicare option at $9.95 per month compared to the Seniors Plus $24.95 premium in 1986. Moreover, the Seniors Plus parent, Group Health, Inc., priced its basic TEFRA Medicare package at $9.95, which included drugs and other expanded benefits. The competing high-option HMO premiums ranged

between $22-29 per month.

To achieve its enrollment target, Kaiser Medicare Plus II avoided competing against itself by curtailing the marketing of its TEFRA Medicare Plus I product in Multnomah County until the S/HMO enrollment target was met. Kaiser reasoned that if the S/HMO and TEFRA option were simultaneously offered to Multnomah County Medicare beneficiaries, the S/HMO could experience an adverse selection (i.e., a disproportionate number of functionally impaired elderly would enroll in the S/HMO option). Once Medicare Plus II achieved its enrollment objective of 4,000 members, Medicare Plus I marketing resumed in Multnomah County in the fall of 1986. In the fall of 1986, when Kaiser offered a choice of Medicare Plus I for $36 per month or Medicare Plus II at $49, 60 percent of the new enrollees selected Medicare Plus II. Because KP dominated the Portland market and in spite of its high premium compared to the competing TEFRA HMOs (with about $29 premiums), the S/HMO achieved its enrollment and demonstrated that it was competitive with Kaiser Medicare Plus I.

It should be noted that in simultaneously offering Seniors Plus and a TEFRA risk option to Twin Cities Medicare beneficiaries, the S/HMO and its parent, Group Health, Inc., set up the competitive situation that Kaiser strategically sidestepped.

During the first 24 months of the demonstration, the S/HMOs in the competitive markets realized that their relatively high premiums adversely affected enrollment. Seniors Plus reduced its premium by approximately $5.00 in March 1986 but still remained noncompetitive with available TEFRA HMO options on the basis of price. Experiencing financial difficulties related to high start-up and administrative costs, SHP determined that it could not afford to reduce premium revenue although it developed two premium options: the regular option of $40 including dental care, and a $24.95 option without dental care and with a $2 physician copayment requirement beginning in January 1987.

The higher S/HMO premiums in the competitive markets would not necessarily have impeded enrollment had the demonstrations effectively differentiated their expanded benefit package from other Medicare health insurance products and precisely identified a distinct market segment among Medicare beneficiaries as probable S/HMO purchasers. While Seniors Plus and SHP attempted to differentiate their products, using a multi-marketing strategy, they did not appear to be successful in this effort. These two S/HMO demonstrations had major difficulties in convincing beneficiaries that their benefit packages were superior to available alternatives and justified the higher premiums.

LACK OF PUBLIC INFORMATION

Interviews of key senior officials and community leaders in each of the site locations 18 months after the S/HMOs had been in operation and marketing showed a considerable lack of understanding about the S/HMO concept along with

confusion as to how the S/HMO was different from the competing HMOs. Even seniors who strongly supported the S/HMOs and who served on S/HMO boards or advisory boards were unable to describe the unique advantages of the S/HMOs. Although many of these senior officials were advocating that seniors join the S/HMOs, the advocates were not effective because they were unable to explain the benefits or value of joining. Public awareness issues were explored more fully from the perspective of the Medicare beneficiaries in Chapter 3.

In Brooklyn, several community leaders recommended that their constituents join the S/HMO if they were feeling sick or frail. Otherwise, they suggested that seniors wait because of the required premium and because the S/HMO was only a demonstration. Similar situations were found in Long Beach and Minneapolis. In Portland, no senior leaders or community leaders reported being aware that KP was offering a S/HMO in one area and a TEFRA HMO in another area. They were only aware that KP was offering a plan to seniors. Thus, the KP S/HMO enrollment did not indicate a demand for a S/HMO as much as a demand for prepayment and a willingness to join KP.

DEMONSTRATION STATUS

The S/HMOs were required by HCFA to inform the public, applicants, and members that the S/HMOs were demonstration projects limited to 42 months. The demonstration status was reported to be a major concern by many consumers, particularly at SCAN and Elderplan, where the S/HMOs could not guarantee enrollment beyond the demonstration period. Because Kaiser and Group Health had TEFRA risk contracts and a sizeable Medicare population, they were able to assure S/HMO enrollees that some type of HMO risk coverage would be provided after the demonstration, even if the chronic care benefits were not continued.

If SCAN and Elderplan did not continue beyond the demonstration period, their members would have to seek other HMO coverage or private insurance. Some elderly individuals were reported to be concerned that if they developed serious illness during the period, they would not be eligible for private health insurance again. They would, however, be able to join another Federally qualified HMO, since such HMOs are not able to screen members from enrollment. A change in plans would likely require a change in physicians. Although the extent of this consideration in the health choice of individuals is unknown, many community leaders, board members, participating physicians, and S/HMO officials expressed the view that this uncertainty was a major barrier to enrollment.

MARKETING S/HMOs

It was possible to have a difficult product to sell with high premiums in a highly competitive market and yet successfully sell the product through effective marketing. However, the experience of the first 24 months of the S/HMO demonstration indicated that, with the exception of KP Northwest, enrollment problems were exacerbated by ineffectual marketing practices. Some of their marketing problems were subsequently resolved and all sites either had met or expected to meet their enrollment targets in 1988.

RESEARCH

Research conducted by SHP, Elderplan, and Seniors Plus prior to initiating marketing led these sites to believe that their benefit packages would be in great demand and that minimal resources would need to be allocated to marketing and selling the S/HMO. The results and interpretation of this marketing research appear to have been misleading.

In its initial marketing research, SHP achieved only a 6 percent response rate to an independently conducted mail survey. Based on this low response rate, SHP concluded that demand for long term care coverage was high and that roughly four out of 10 Long Beach beneficiaries would change their insurance and physician to join the S/HMO. Based on an independent telephone survey of 352 Medicare beneficiaries with a respectable 88 percent response rate, Seniors Plus found that only 8 percent of respondents reported a willingness to change their insurance coverage and/or physician. Yet Seniors Plus staff found these results encouraging. Having conducted a survey similar to that of SHP and Seniors Plus, Elderplan found that while 30 percent of individuals were dissatisfied with the costs of hospital care, physician services, and their Medicare supplemental insurance, while only 14 percent said they would be willing to switch coverage or physicians to join the S/HMO. Elderplan found the 14 percent who were willing to change encouraging since they were attempting to reach 10 percent of the population.

These initial surveys generally did not ask detailed questions about possible consumer decisions relative to specific plan benefits or premium levels and did not probe the potential impact of a "lock-in" requirement or the time-limited demonstration status of S/HMOs on potential enrollment. More importantly, the initial research generally did little to help the demonstrations identify effective advertising themes, nor was it useful in guiding the plans in making critical decisions about structuring their benefit packages, setting premium levels, and choosing acceptable health care providers. Subsequent marketing research, including focus groups, was conducted by three sites after they experienced difficulties in meeting enrollment targets. The results of these later studies were used in refining advertising strategies, marketing activities, premiums, and benefit packages.

EXPERIENCE

The foundation of the S/HMO model was its acute care prepaid health care delivery system. Kaiser had had extensive experience in such marketing -- experience gained through its successful Medicare capitation demonstration project from 1980-1985 (i.e., Medicare Plus I). Group Health, Inc., the Seniors Plus parent, had more limited experience. The Group Health TEFRA risk contract marketing only began in spring 1984, and most of its enrollment was gained through conversions from its Medicare Health Care Prepayment Plan (HCPP) contract. The other S/HMO sites did not have this experience.

Successful marketing of the S/HMO at KP reflected the coordinated efforts

of the director of the S/HMO demonstration and the director of marketing, Kaiser Foundation Health Plan. Kaiser Foundation Health Plan marketing personnel and an outside artist and advertising agency translated the creative ideas of S/HMO staff into sales literature. This working relationship between the S/HMO demonstration and Kaiser Health Plan marketing was an outgrowth of similar efforts to market Medicare Plus I when it was a Medicare capitation demonstration. In both Medicare Plus I and Medicare Plus II, special attention was paid to having these demonstrations marketed in a manner consistent with Kaisers' overall strategic growth objective of enrolling the aged in numbers proportionate to the market area's aged population.

In contrast to the stability and continuity of the marketing process at Kaiser, marketing staffs at the other S/HMO sites lacked health care marketing expertise, and high turnover rates occurred. For example, during the first 24 months of the demonstration, Elderplan had 3 marketing directors, Seniors Plus had 3, and SHP had 3.[12] Except at Seniors Plus, this turnover reflected organizational dissatisfaction with marketing and enrollment success. Problems with and confusion over how to position creatively the S/HMO product was also reflected in the two changes in advertising agencies employed by SCAN Health Plan.

ADVERTISING STRATEGY

A review of S/HMO advertising material revealed that KP and Elderplan decided to promote the demonstration as a comprehensive prepaid health plan whereas marketing at SHP and Seniors Plus initially emphasized the S/HMO chronic care benefits.

These marketing strategies appeared logical. Elderplan faced no TEFRA HMO competition in its market and needed to use marketing resources to inform Brooklyn seniors about the more general advantages of prepaid health care. Similarly, KP's desire to have the S/HMO be consistent with KP's corporate objectives argued for treating the demonstration simply as a new offering, another option for seniors that KP was willing to stand squarely behind. By contrast, SHP and Seniors Plus recognized that in their competitive markets, the S/HMO concept would somehow have to be clearly differentiated from TEFRA HMO alternatives if it was to sell. In this sense, SHP and Seniors Plus faced a greater marketing challenge than the other demonstration sites.

In selecting its name, Medicare Plus II, and in conceiving its advertising brochure, KP made little effort to differentiate the S/HMO concept from that of its comprehensive TEFRA HMO, Medicare Plus I. This demonstration banked on the KP's reputation as its chief marketing tool. S/HMO promotional literature focused on the stability of the KP Health Plan and the comprehensiveness of its services. It was clear to prospective enrollees that if they joined Medicare Plus II, they would be full KP Health Plan members.

The primary message promoted by Elderplan in its plan brochure was the availability of comprehensive care. The demonstration did not highlight the availability of expanded long term care coverage. Elderplan was presented as

a health plan alternative to standard Medicare coverage (i.e., "Take the Worry Out of Medicare: Add Health to Your Years"). In promoting its message, Elderplan faced the additional problem that many Brooklyn seniors were unfamiliar with the HMO concept. Moreover, if they knew about HMOs, their knowledge was probably gained from experience with HIP. Since Elderplan did not want to be identified with HIP, it did not attempt to identify itself as an HMO. While the initial interest in Elderplan was favorable, actual enrollment was low.

Beginning in the sixth quarter, Elderplan began a new marketing and enrollment campaign that was associated with a steady increase in enrollment. The themes for this campaign included: "You've Worked Hard All Your Life; Find Out the One Health Plan That Keeps Seniors Well and Well Covered;" and "Elderplan -- the Neighborhood Health Plan." The plan also launched a direct ad attack on its major competitor with: "Blue Cross-Blue Shield the Best Medicare Supplement Around. Right? Wrong!" These themes were considered by Elderplan to be partially responsible for the improvement in enrollment rates.

Both SHP and Seniors Plus emphasized the long term care theme in their promotional literature. Seniors Plus marketing material initially reflected the difficulty of positioning the S/HMO product in the competitive Twin Cities market. For example, while one brochure contained pictures of attractive older couples with no apparent impairments, most materials focused on long term care. One brochure showed an overweight, smiling woman being cared for at home and another, showed a woman recuperating at home with her foot in a cast. The Seniors Plus ad themes included: "Introducing the Newest Alternative to a Nursing Home: Your Home"; "The Health Plan You've Waited a Lifetime For"; and "A Seniors Plan That Helps Preserve Your Health and Independence." Although Seniors Plus also advertised the comprehensiveness of its benefits and other HMO-related messages (e.g., elimination of confusing paperwork, ability to choose from over 200 Group Health physicians, preventive health care), home care/long term care was the principal theme.

In contrast, the Group Health, Inc. TEFRA HMO plan, Seniors, marketed simultaneously with the S/HMO, was similar in tone to Kaiser Medicare Plus II: "If you join Seniors, you have all the benefits of being a member of Group Health, Inc." The message contained in Group Health advertising was that the TEFRA risk contract was for active healthy older persons, an image fostered by the other Twin Cities TEFRA HMOs as well. The message appeared to be clear and the enrollment doubled (see Figure 3). In contrast, the plan image fostered in Seniors Plus marketing materials was confusing: was this option for all seniors or for older persons in need of long term care? If it was for all seniors, then what differentiated it from the Group Health TEFRA risk contract and other TEFRA HMOs in the area?

Like Seniors Plus, SHP attempted to differentiate itself through a health care protection theme. In its brochure, "Presenting a Better Health Package for Long Beach Seniors," SHP advertised better care against "devastating financial effects of long term illnesses." After this campaign appeared to meet with little success, SHP also decided in summer 1985 to use a

confrontational advertising campaign against its major competitor, FHP, Inc. In newspaper advertisements that ran over a six-month period, SHP used ads saying "Don't Be Herded into the Wrong Senior Health Plan" and "We Treat Patients Like People". These campaigns implied that FHP enrollees were dissatisfied with the care they had been receiving. In contrast, the FHP marketing message, "Premium Health Care Without the Premiums," appealed to active healthy seniors and to persons who could not afford to pay large out-of-pocket premiums for Medicare supplemental insurance.

The consensus of HMO competitors and consumer representatives interviewed was that SHP's anti-FHP campaign was confusing (some felt SCAN members were being herded into the plan) and ineffective in either attracting fee-for-service beneficiaries or in encouraging FHP members to switch to SHP. In 1986, SCAN moved to advertising themes that stated: "We Take Care of You at Home; We Make House Calls and Protect Your Nest Egg." These themes still primarily emphasized long term care services and insurance advertising themes and seemed to have little appeal to seniors.

ACTIVITIES

Kaiser Permanente did not use television and media advertising to promote the S/HMO demonstration as it did in marketing Medicare Plus I, but relied almost exclusively on direct mail and community presence. KP's marketing plan had two parts (see Table 4). First, KP conducted a direct mail campaign to approximately 75,000 Medicare beneficiaries in Multnomah County. This mailing resulted in a 10 percent response and of these, a 20 percent closure rate (i.e., 2 percent joined Medicare Plus II). The second part of KP's marketing approach was to convert existing KP members from the KP Medicare cost contract. KP's focus on converting at least 2000 cost contract members was further motivated by the 2 to 1 conversion rule (for every 2 conversions, 1 new enrollee) under the 1982 TEFRA regulations repealed by OBRA (1986). KP had a strong response rate with its mailings to cost contract members (19% of 4300 members decided to convert to Medicare Plus II during the second quarter). KP did not direct any Medicare Plus II marketing to the members of the KP Medicare Plus TEFRA risk contract living in Multnomah County. Although there was no restriction to prevent Plus I members from switching into Medicare Plus II, few of them did so.

In the third quarter, after Medicare Plus II became operational and enrollment was only 1,780, KP realized that without additional marketing efforts, the enrollment target would not be met. In the fourth quarter, KP conducted a second direct mail campaign to 11,000 persons aged 65-67 and to 3,000 KP cost contract members (Table 4). These efforts resulted in meeting its target by the sixth quarter, primarily by obtaining conversion members.

In contrast to KP, the other demonstrations had great difficulty in marketing the S/HMO. Based on their research, these groups believed there was such great demand for the S/HMO product that it would sell itself. The S/HMOs had confidence in the initial marketing materials which they had developed. As they realized this was not the case, marketing efforts increased

Table 4

KAISER S/HMO MARKETING ACTIVITIES BY QUARTER IN 1985 AND 1986

Kaiser	1985				1986			
	1	2	3	4	5	6	7	8
Activities								
Television	0	0	0	0	0	0	0	0
Radio	0	0	0	0	0	0	0	0
General Newspaper # Ads	0	2[a]	0	0	0	0	0	0
Senior Newspaper # Ads	0	0	0	0	0	0	0	0
Billboard/Posters	0	0	0	0	0	0	0	0
Individuals Receiving Group Presentations	0	90	260	171	785	285	30	470
Other Group Presentations	0	0	86[b]	0	0	0	0	220
Direct Mail	0	75,300[c]	0	14,000[d]	18,765[e]	16,096[f]	0	41,000[g]
Responses								
Application Kits Mailed	NA	5,435	1,050	1,600	157	892	17	1,800
Phone Calls	NA	3,000	NA	150	NA	NA	NA	NA
Walk-in	NA	0	NA	25	NA	NA	NA	NA
Response Rates	-	11.9%	-	5.7%	8.0%	6.8%	-	-
Marketing Budget Cumulative[h]				$101,711		$20,220		$16,873

Source: Quarterly reports from Kaiser and unpublished data. Portland: Kaiser Research, 1986.

[a] Local paper with 288,000 circulation.
[b] Group presentations for (AFS) Medicaid members by the 6 local welfare offices.
[c] Included 4,300 Kaiser members and 1,300 of those joined.
[d] Included mailings to all Kaiser Medicare members and 11,000 mailers to the 65-67 year olds listed by the Department of Motor Vehicles, this effort resulted in a response from 425 people and resulted in 85 new members.
[e] Included letters to 18,765 Medicaid members.
[f] Included mailing to 13,096 Medicaid AFS members, 2,000 Medicaid members on the HCFA list, and 100 Kaiser members.
[g] This mailing was conducted by Kaiser for the dual choice of Medicare Plus I and Plus II.
[h] The $101,711 is the total for the first four quarters and includes $86,636 in direct expenses and $15,075 in contributed expenses by the Kaiser marketing director. The $20,220 is the total marketing expense for the first and second quarters of 1986. The $16,873 is the total for the third and fourth quarters of 1986.

substantially at all three sites.

Elderplan also relied heavily on direct mail (see Table 5). During the first nine months of the program, the plan mailed over 400,000 information packets to area seniors, resulting in approximately 15,000 application requests. In conducting this direct mail campaign, Elderplan's inexperience in marketing was evident -- the telephone numbers of callers for application kits were not obtained, making it extremely difficult to pursue these leads and convert them to sales through tele-marketing follow-up. The plan had a marketing director and associate, but no sales representatives or enrollment counselors to handle the inquiries after the mailings. While the initial interest in Elderplan was 2.5-5 percent from the mailing, Elderplan failed to enroll many who indicated interest.

After the first 12 months, Elderplan reassessed its marketing strategy because it had enrolled a net of only 770 beneficiaries. The plan increased its direct mail and advertising efforts, hired a new marketing director, and trained a sales staff and a marketing coordinator. These staff changes improved the ability of Elderplan to enroll members. The General Director directly managed the new effort which also involved telemarketing, newspaper and radio advertising, senior salespersons, and expanded community presentations.

Seniors Plus also used direct mail advertising but did not begin until its third operational quarter, and then to only 11,700 persons (10 percent of Medicare eligibles in the market) (see Table 6). Only 0.7 percent of persons contacted during this mailing enrolled. Initially, Seniors Plus had hoped to attract members from GHI and Ebenezer with a minimal marketing effort. There was also a delay in the first three months when the project changed its name to Seniors Plus and new marketing materials were developed.

During the third quarter, Seniors Plus assessed its marketing approach because enrollment stood at only 340 persons. Seniors Plus decided to expand its service area, increase the budget for mass media advertising, increase the number of sales presentations to community groups, and continue to rely on direct mail. In spite of these plans, Seniors Plus conducted a limited marketing and direct mail effort because they claimed they had little confidence in their marketing materials and were reluctant to spend money on large-scale advertising campaigns without knowing who was being attracted to the S/HMO and what features of the plan were appealing to enrollees.

Internal management disputes at Group Health were reported to have played a primary role in these initial delays in marketing the S/HMO. A change in leadership of Group Health occurred after the S/HMO had been approved so the project was reassessed but not given a high priority and marketing resources were not allocated. Some Group Health managers were concerned about adverse selection in Seniors Plus in market competition with Seniors. Others indicated that Group Health lost money on every S/HMO enrollee (because the premiums were set low to be competitive with other HMOs) and made money on every Seniors enrollee. Therefore, initially the clear preference of the

Table 5

ELDERPLAN S/HMO MARKETING ACTIVITIES BY QUARTER IN 1985 AND 1986

Elderplan	1985				1986			
	1	2	3	4	5	6	7	8
Activities								
Television	0	0	0	0	0	0	0	0
Radio	0	0	27	0	0	20	62	3
General Newspaper # Ads	8	2	3	0	13	26	30	24[a]
Senior Newspaper # Ads	1	0	0	0	0	0	0	0
Billboard/Posters	0	0	0	0	0	0	0	0
Individuals Receiving Group Presentations	571	824	205	670	3,250	470	547	475
Other	2,000[b]	7,800[b]	2,200[b]	0	0	0	0	0
Direct Mail	26,004[c]	149,000	229,000	0	0	274,771	254,389	228,000
Responses								
Application Kits Mailed	0	10,245	5,380	1,500	1,700	1,800	3,838	1,647
Phone Calls	609	1,245	809	750	600	1,500	1,659	1,647
Walk-in	51	215	105	50	120	60	281	191
Response Rates[d]	2.5%	5%	2.7%	-	2.6%	1.2%	2.3%	1.5%
Budget Expenses	$165,180	$143,800	$181,885	$116,765	$185,283	$226,308	$348,169	$280,917
Staff	7,641	27,549	35,520	19,868	52,436	79,522	99,606	74,880
Advertising	157,540	116,251	146,396	96,897	132,847	146,786	248,563	206,037

Source: Quarterly reports and unpublished data. Brooklyn: Elderplan, 1986, 1987.

[a] A total of 50,000 ad pieces were inserted in the Sunday N.Y. Times.
[b] Shopping bags distributed to merchants.
[c] 26,004 application kits were mailed as a part of the direct mail campaign.
[d] Response rates were calculated by dividing the total responses by the direct mail pieces.

Table 6

SENIORS PLUS MARKETING ACTIVITIES BY QUARTER IN 1985 AND 1986

Seniors Plus	1985				1986			
	1	2	3	4	5	6	7	8
Activities								
Television	0	0	0	0	0	0	0	0
Radio	0	0	0	0	0	8[a]	0	0
General Newspaper # Ads	0	5	7	8	8	-	0	0
Senior Newspaper # Ads	0	1	1	0	3	16	0	0
Billboard/Posters	0	13	0	0	0	2	0	0
Individuals Receiving Group Presentations	438	116	122	902	710	635	160	1015
Other Group Presentations	0	800	320	1,344	580	450	0	0
Direct Mail	5,606	1,613	11,700	17,048	34,502	414,000	330	55,000
Responses								
Application Kits Mailed	416	143	351	475	727	4,008	1740	1292
Phone Calls	715	163	317	517	709	4,757	541	476
Walk-in	-	5	12	13	9	36	7	30
Written Requests	-	-	-	-	-	-	-	257
Response Rates[b]	20%	19%	5.8%	5.9%	4.2%	2.1%	-	3.7%
Marketing Expenses	$10,543	$8,862	$55,544	$106,462	$234,229	$311,386	$23,576	$45,253
Staff				2,828	23,478	28,772	12,728	5,328
Advertising				103,634	210,751	288,614	10,848	39,925

Source: Seniors Plus quarterly reports and unpublished plan data. Minneapolis, MN: Seniors Plus, 1986, 1987.

[a] The radio ads were 4 different ones run for 6 weeks at a time over two periods.
[b] Response rates calculated by dividing total requests by the total direct mail sent.

organization appeared to be to feature Seniors and to limit advertising of Seniors Plus.

It was not until 16 months after Seniors Plus began operations that it initiated a large-scale direct mail campaign. After pilot testing three similar brochures (all with long term care messages) on groups of 10,000 older persons, one information flyer was sent to over 100,000 persons in May 1986. In spite of continuing large-scale direct mailings in spring 1986, the response of only 88 new members (the remainder of new enrollees were conversions) was disappointing. In addition to direct mail, Seniors Plus used newspaper and radio advertising and hired a telemarketing firm in spring 1986. The direct mail efforts were then significantly reduced in the last two quarters of 1986. After 24 months, total net enrollment was only 1,688 persons. Seniors Plus attributed its failure to a saturated market and a product of little interest. Other contributing problems appeared to be that its marketing messages of long term care did not appeal to the elderly, and that the direct mail efforts primarily occurred during one quarter of the two-year period.

Group Health advertising of its TEFRA Seniors stands in contrast to the Seniors Plus effort, because Seniors marketing primarily used the media — newspapers and radio — and did not rely on direct mail. Greater resources were invested in the marketing effort for Seniors and, as noted above, the marketing message for Seniors was geared toward comprehensive services for active healthy persons. The result was that the enrollment in Seniors doubled during the period, and other senior HMOs also continued to grow in the area during the period (see Figure 5).

SCAN conducted a series of quarterly direct mail campaigns to almost 200,000 persons during the first 12 months of the demonstration (see Table 7). The overall response to these mailings was less than one percent. The direct mail effort was reduced during the second year to about 112,000 mailings, including homeowners and Medicaid members. In addition to direct mail, SCAN made a number of presentations to senior citizen groups and used extensive newspaper advertising. SCAN did not test different marketing materials and approaches in either ads or mailings. The mailing materials described above were not attractive in appearance or message as judged by the S/HMO evaluators. Efforts to target special groups were limited to homeowners, MediCal members, and individuals with Blue Cross/Blue Shield supplemental policies. Overall, SCAN marketing efforts were limited and unfocused. Because of its limited geographical area and the high costs, SHP was not able to use television, although cable television was later utilized. In contrast, FHP as the major competing TEFRA HMO in the area did not use direct mail, but used extensive amounts of television, newspaper advertising, radio, special community meetings, and letters from physicians. The broad-based and highly aggressive marketing by the FHP overwhelmed the direct mail activities used by SCAN.

Table 7

SCAN S/HMO MARKETING ACTIVITIES BY QUARTER IN 1985 AND 1986

SCAN	1985				1986			
	1	2	3	4	5	6	7	8
Activities								
Television	0	0	0	0	0	0	0	168[a]
Radio[a]	0	0	18	198[b]	0	0	0	0
General Newspaper # Ads	20	23	50	31	20	33	24	41
Senior Newspaper # Ads	3	3	15	5	1	6	2	0
Billboard/Posters	0	0	15	335[c]	0	0	0	0
Individuals Receiving Group Presentations	1,011	2,793	315	376	410	214	620	591
Other Group Presentations	0	0	0	326	520	336	400	0
Direct Mail	20,004	86,000	9,000	81,000	0	72,603	40,174	NA[d]
Responses								
Application Kits Mailed	NA	1,039	NA	NA	NA	NA	NA	NA
Phone Calls	NA	204	672	300	423	216	439	607
Walk-in	NA	121	223	58	88	38	40	77
Other Inquiries	-	-	-	-	-	520	696	1,214
Response Rates[e]	>1%	1.6%	>1%	>1%	-	-	-	-
Budget Expenses	$70,009	$179,423	$332,685	$184,818	$140,901	$212,544	$186,402	$230,348
Staff	11,287	55,470	63,759	79,895	77,506	92,328	75,590	91,844
Advertising	58,722	123,953	268,906	104,923	63,395	120,216	110,812	138,504

Source: SCAN Quarterly reports and unpublished data. Long Beach, CA: SCAN, 1986, 1987.

[a] 84 commercials per week over two weeks on a local cable TV channel.
[b] Total number of radio announcements.
[c] Included 15 billboards and 320 posters.
[d] Also sent letters from 2 primary care physicians and signed up 75 private insurance brokers to sell the plan, using in-house telemarketing.
[e] Response rates based on reports by SCAN staff.

Group Marketing

S/HMO marketing efforts generally focused on convincing individuals to select an alternative to standard Medicare coverage. At the same time, the S/HMOs were attempting to influence employer and union representatives to offer the demonstration as a retiree group benefit. The competing TEFRA HMOs estimated that about 10 percent of their Medicare members were enrolled through retiree group contracts.

Elderplan worked particularly hard to convince the Brooklyn Union Gas Company (the largest employer in the Borough), New York Telephone, and the New York State/City Employee Benefit Programs to offer Elderplan as a benefit option for their retirees. Elderplan found that the obstacles to marketing the S/HMO to these groups were formidable. The three principal impediments to group marketing were Elderplan's limited service area (i.e., retirees living in Queens or other Brooklyn zipcode areas could not join), the time-limited demonstration status of the project; and the relatively limited physician choice. At the end of 24 months, Elderplan had only signed the New York State retirees group and had 7 group enrollees out of 200 members in the area.

Kaiser Permanente experienced a similar problem in trying to market the S/HMO to Portland's largest employer, Techtronics, Inc. and to the Longshoremans Union because only Multnomah County beneficiaries were eligible to join. Techtronics did elect to offer retiree membership to one of the competing HMO plans in the area rather than KP. KP only had 47 group members (1%) out of its total S/HMO enrollment at the end of the first 24 months.

During the first 24 months, SHP was able to develop three eligible small group policies for retirees with only a few enrollees. SHP focused its group marketing efforts in the McDonnell Douglas Corporation, which had an estimated 5,000 eligible retirees in the Long Beach area. This effort was impeded because the company did not want to offer a plan that only served persons over 65, that is, not having a commercial HMO so that the employer could use one organization for all its members. They urged SHP to join forces with another HMO with an under-65 enrollment. After one year of negotiations, SHP obtained a contract with McDonnell Douglas in conjunction with the Health Plan of America HMO. This plan was finally made available to about 1,000-1,500 enrollees after January 1987, but enrolled only approximately 130 new members. Eventually SHP reported having 5% of its members enrolled through group plans.

Seniors Plus was relatively successful in group marketing. Between March and August 1986, however, Seniors Plus was not allowed by HCFA to differentiate between individuals and groups in its queuing procedures. During that period, potential group contractors objected to the Seniors Plus queuing provisions that screened and limited the numbers of severely impaired persons who could enroll (to no more than 5% severely impaired). Employers wanted their severely impaired retirees to be able to bypass the queue. Prior to March 1986 and after September 1986, Seniors Plus enrolled 549 members or approximately one-third of their total enrollment through 11 retiree groups. The largest number of group members came from Federal retirees and the

University of Minnesota retiree group.

Medicaid Marketing

The minimal Medicaid marketing efforts at all four sites had extremely limited responses. KP conducted two direct mailings to Medicaid members in the fifth and sixth quarters of the project, but with limited success. Elderplan conducted direct mailings of 15,000 in March 1986 and of 21,095 in June 1986. The response was only 332 to the last mailing, and enrollments were low.

Seniors Plus also had no success in enrolling Medicaid members. The plan mailed to about 3,500 Medicaid noninstitutionalized elderly in October 1985 and again in the spring of 1986. The plan also mailed brochures to 300 Medicaid elderly in Ebenezer nursing homes. These mailings had such a poor response that senior officials felt there was no reason to continue marketing. Meanwhile the state Medicaid agency assumed responsibility for the marketing of all competing plans (using a private contractor) during the period of November 1986 through January 1987.

SCAN did its first direct mailing to 9,000 Medicaid members living in their area during the third quarter of 1985. This mailing resulted in only 54 new Medicaid members during that quarter and 39 new members in the following quarter. A second direct mailing was sent to 9,000 Medicaid members in the summer (the seventh quarter) of 1986, and again only 35 members joined in that quarter.

SHMO representatives believed that the poor Medicaid enrollment was related to the lock-in feature of the plan, the lack of incentives to join, the wide availability of private practitioners to accept Medicaid patients in those areas, the coverage of all copayments, and other factors. In addition to these factors, the advertising materials used may not have been appealing since they were not particularly tailored to the Medicaid group, except for the explanation of the benefits and the lack of premiums. Marketing materials generally did not stress the particular advantages for Medicaid members in terms of quality of care, access, continuity of care, and personal attention (and 6-month guaranteed Medicaid coverage in New York). Direct marketing presentations were also generally not conducted at geographical locations where Medicaid recipients lived or congregated.

In addition, New York Medicaid officials were concerned that the poor enrollment in Brooklyn may have been due to the location of the Elderplan physician group in a middle-class area, and the failure to develop clinic sites in the heavily populated Medicaid areas on the periphery of the service area.

Marketing Budgets

Except for KP, all initial S/HMO marketing budgets proved inadequate. Tables 4-7 summarize marketing expenditures over the first 24 months of the

demonstration.

The lack of marketing expenditures was most acute at Seniors Plus, particularly during its first 12 months (see Table 6). Because Seniors Plus did not anticipate any difficulty in enrolling beneficiaries, the plan set aside only $181,000 for marketing. Even when marketing expenditures were increased dramatically during the spring of 1986, the response was minimal. Although total expenditures increased to about $800,000 during the first 24 months, the increase represented a marketing cost of only about $470 per enrollee. Discounting the number of S/HMO enrollees who converted from the Group Health, Inc. TEFRA HMO, marketing costs soared to $1,650 for every new enrollee. Having projected spending approximately 2 percent of its revenue on marketing, Seniors Plus actually spent 20 percent of revenue on marketing during its first 24 months and still met with limited success. In contrast, Group Health reportedly allocated significantly more resources to Seniors for marketing. The marketing for Seniors focused on newspapers and radio messages that were more expensive than the direct mail approach used by Seniors Plus.

Elderplan's total marketing salary and advertising budget averaged around $170,000 per quarter, over $1 million for the first 18 months, and $1.6 million in 24 months (see Table 5). These expenditures represented about $640 per enrollee. The initial marketing expenditures were not related to enrollment success, but during the second year, enrollment began to climb steadily.

SHP marketing expenditures were similar to those of Elderplan (see Table 7). By the end of the first 24 months, SCAN had spent over $1 million on marketing, representing about $439 per enrollee. Of the total marketing expenditures, 53 percent was spent on marketing staff. Of the total SHP marketing staff, two were marketing and public relations directors and the remaining staff were sales representatives and support staff.

In contrast to the other sites, KP reported total staff and advertising expenditures for marketing of $139,000 for the first 24 months. This represented approximately $32 per enrollee (see Table 4). KP's expenditures were significantly less than those of the other S/HMO projects, which could be accounted for by a number of factors. These included less marketing competition in the area, a focused direct mail approach, the large name recognition of KP in the area, greater expertise of KP in marketing to the elderly, organizational efficiencies, and the ability to convert KP members from its cost contract.

It should be noted that during the first 24 months, only KP had a full risk-sharing arrangement with HCFA. For the other three S/HMOs, once each SHMO reached its risk ceiling of $250,000-500,000 annually, Medicare and Medicaid paid for all losses. Thus, the marketing expenditures were directly paid for by HCFA for three sites. This gave the sites little incentive to be cost effective in testing and targeting their advertising efforts. Seniors Plus did conduct extensive testing of some of its products, but still had difficulty in achieving its desired effects from their advertising materials.

In contrast to the S/HMOs, most competing TEFRA HMOs studied had large budgets for advertising to Medicare beneficiaries. This finding was consistent with data from Florida Medicare risk contractors who used about 6 percent of their total expenditures on marketing (U.S. General Accounting Office (GAO), 1986). Langwell et al. (1986) also found that the TEFRA demonstration projects had sizeable marketing budgets, and a relationship appeared to exist between larger marketing budgets and larger enrollments.

The competing TEFRA HMO marketing budgets appeared to be substantially higher than the S/HMO marketing budgets in the more competitive markets of Los Angeles and Minneapolis. Even the older and better established TEFRA HMOs had sizeable marketing budgets in Los Angeles and Minneapolis. In Southern California, two plans reportedly spent over $1 million in advertising within the first 6 months after their initial enrollment activities began. Another reported spending over $3 million. One large TEFRA HMO competitor of SHP reported targeting 15 percent of their expected revenues for marketing. The large Medicare HMOs in Minnesota had comparable advertising budgets, although some plans had more modest budgets of around $300,000 per year. The competing plans that used the television media had significantly higher expenses.

Elderplan argued that the high costs were necessitated by the negative attitude of New Yorkers to HMOs and the newness of the HMO concept. They argued that the 1986 marketing expenditures of over $10 million by competing HMOs for less than 100,000 new members indicated how difficult it was to penetrate this market.

DISCUSSION

This chapter explores a number of factors considered to be associated with the successful enrollment of KP Medicare Plus II and the poor enrollment of the other three S/HMOs during the first 24 months.

Large, long-standing HMOs like KP with previous TEFRA demonstration project experience may be more able to market successfully the S/HMO project than new, inexperienced HMOs. However, Group Health, for a variety of reasons, was not able to capitalize on its size, age, and well-established reputation in meeting its S/HMO enrollment targets. The competitive market and GHI's late entry into the elderly market compared with other HMOs in its area were two such reasons.

Provider networks are important features in marketing HMOs and S/HMOs. Limited physician and hospital services in comparison to other available resources in the community were particular problems for three S/HMOs. The S/HMOs with limited numbers of physicians were at a disadvantage in providing access to services and convincing seniors to switch physicians. The limited geographical location of physicians and hospitals also appeared to be a concern. The reputation of the providers was another important factor in marketing appeal.

The competitive market environment, especially in Long Beach and Minneapolis, was a major factor negatively affecting S/HMO enrollment. The large number of competing plans and high market penetration in these areas created major marketing disadvantages to the S/HMOs. The effect of the competition was not predicted in the early planning stages as the S/HMOs were delayed a year in 1984 while many HMO risk contract demonstrations were being introduced or expanding. By 1985, the S/HMOs faced TEFRA HMO competitors that had already enrolled large numbers of elderly persons. Timing in the market was favorable for KP S/HMO which entered before its competition began to emerge.

The issue of the effect of marketing a S/HMO and a TEFRA HMO similtaneously was not resolved. KP avoided marketing its two plans in the same market area until the S/HMO reached its marketing target. When dual choice was offered by KP, the S/HMO received a higher percentage of new enrollments. The low enrollment in Seniors Plus in comparison with its TEFRA Seniors plan, both of which were marketed similtaneously, appeared to be related to several factors, including substantial differences in premium prices as well as differences in marketing messages, advertising approaches, and relative resources allocated to marketing. Seniors Plus did have the advantage of converting some of its elderly members to its plan, like Kaiser Permanente.

All of the S/HMO demonstration projects were at a significant disadvantage as compared with the competition because of their geographical market areas. Group enrollment was limited (except at Seniors Plus) because employers, and particularly union representatives, were seeking broad geographical coverage to assure that all their Medicare members would have access to the same coverage. Competing HMO risk contractors all used broad geographical target areas that allowed for more effective use of mass newspaper, radio, and television media in their marketing.

Premium prices appeared to be an important barrier to in S/HMO enrollment in the competitive market areas (Long Beach and Minneapolis/St. Paul). The S/HMO premiums were somewhat higher than those of the HMO competition in their areas, even high-option TEFRA plans. Prices may have been even more important where employer retirement benefits were limited, as in Minneapolis and Portland. The price competition appeared to be even more important for new Medicare HMOs and S/HMOs with little name recognition, which probably needed to be able to meet the lowest market prices in an area in order to compete effectively.

Two S/HMOs (Medicare Plus II and Elderplan) did not attempt to differentiate their benefits from those of basic and high-option TEFRA HMOs in the area. Seniors Plus and SHP did attempt to differentiate their benefits but had little success with this effort. Generally, senior representatives, providers, employers, unions, and community leaders knew little about S/HMO benefits and could not distinguish them from competing TEFRA plans. Also, most senior leaders associated with S/HMOs in the community did not understand what issues were being tested by the demonstration.

Only two S/HMOs developed advertising messages emphasizing long term care benefits, and these two had low enrollments. Such messages appeared confusing, implying that S/HMOs were not for the typical healthy elderly person. With so many other problems in marketing the S/HMOs, it was unclear whether or not the message was the wrong one for attracting enrollees or whether the high premiums in comparison to TEFRA HMOs, limited benefits in comparison to some long term care plans (which are allowed to screen), provider services, geographic limitations, inexperience, and other factors such as the competitive environment were the major factors limiting enrollment.

Initially, the demonstrations did not fully appreciate the problems of marketing a new product. Except at Elderplan, they failed to plan sizeable marketing budgets in the first six months and did not fully anticipate the marketing efforts of their competition. Almost a full year of operation had elapsed before the three S/HMOs recognized the limitations of their marketing activities and budgets. Although they began to increase their marketing efforts at that time, the funds appeared to be spent too late to achieve the target goals in the first 24 months. Since that time marketing efforts have begun to pay off and have either met or expect to meet their targets in 1988.

Reflective of these budget decisions, the S/HMOs with enrollment problems initially did not utilize aggressive and sophisticated marketing practices in comparison to the TEFRA HMOs, particularly in competitive market areas. The most successful Medicare HMOs utilized an active multimedia approach, combining television, newspaper advertising (especially in senior publications), radio, direct mail, special seminars, and letters from physicians encouraging enrollment. The S/HMO marketing efforts, in contrast, relied almost solely on direct mail from the HCFA Medicare eligibility lists and telemarketing, with little use of mass media.

In summary, after their first 2 years of operation, three of the S/HMOs had to confront a formidable challenge in establishing themselves as viable health plans within their communities. They have achieved enrollment levels adequate for exploring and testing many of the broad health policy questions originally posed by the demonstration, and their enrollment has continued to grow.

On the other hand, the way in which the S/HMO concept was marketed made difficult an exploration of the fundamental question of consumer interest in long term care coverage within the framework of a comprehensive prepaid health plan. Although the marketing effort by the S/HMOs was great, the effectiveness in marketing a long term care insurance product was limited. The enrollment success or failure of the S/HMO demonstration seemed to be a function of how well these plans competed as HMOs, rather than whether people were offered the choice of a high-option chronic care health plan and rejected it.

SUMMARY FINDINGS

- Only one S/HMO demonstration, KP's Medicare Plus II, met its Medicare enrollment target of 4,000 members within the first 24 months of operation. The other three sites had slow, steady enrollment patterns substantially below their targets.

- None of the S/HMO sites met their Medicaid enrollment targets.

- The long standing reputation and experience of KP's HMO aided its S/HMO enrollment efforts. S/HMO sponsorship by experienced long term care organizations did not appear to enhance S/HMO marketing efforts.

- The hospital and physician providers selected by SCAN Health Plan and Elderplan may have had negative effects on marketing.

- The limited number of ambulatory service sites may have negatively affected enrollment at SCAN and Elderplan.

- The limited geographical market areas established by all four of the S/HMOs created a marketing disadvantage in competing with TEFRA HMOs, limited the effective use of media, and limited enrollment by group purchasers such as large employers. While all sites made some changes in their geographic area, only Seniors Plus expanded to its entire metropolitan area and was able to achieve a sizeable group enrollment.

- The S/HMOs were competing with HMOs and Medigap insurance policies at all four sites. The number of large competitive TEFRA HMOs and the high market penetration created highly competitive market environments in Los Angeles and Minneapolis-St. Paul that negatively affected the enrollment at SCAN and Seniors Plus.

- At the two S/HMOs (SHP and Seniors Plus) where the LTC benefits were advertised, the benefits were not differentiated effectively from those offered by the competing HMOs. Medicare Plus II and Elderplan did not attempt to differentiate their products from other HMOs.

- While the S/HMO chronic care benefit package (of $6,500-$12,000 annually) was greater than other available TEFRA HMO coverage, these benefits may have been viewed as limited by potential enrollees in relationship to long term care insurance options. Other potential enrollees may not have been aware of the limited long term care coverage of plans options.

- The premium levels of SHP and Seniors Plus were high in comparison to the basic and high option of the major competing TEFRA HMOs, creating a substantial marketing disadvantage.

- Lack of understanding of the S/HMO concept by seniors and community leaders was a negative factor in enrollment at SHP and Seniors Plus where KP an attempt was made to distinguish the S/HMO from its TEFRA HMOs.

- The demonstration status of the projects was a negative feature in marketing the Elderplan and SCAN S/HMOs because these organizations could not guarantee HMO coverage beyond the demonstration period.

- Marketing experience with Medicare beneficiaries was limited at all S/HMO sites except KP. High turnover rates in marketing directors occurred at three sites.

- Advertising efforts at KP and Elderplan that focused on comprehensive benefits for healthy older persons appeared to have a stronger appeal than the long term care services and protection messages utilized by SCAN and Seniors Plus.

- Problems in developing a clear and sustained marketing effort had negative effects on enrollment at SCAN and Seniors Plus. While Elderplan had problems initially in its marketing efforts, marketing and enrollment improved during the second year.

- All S/HMO sites directed their efforts primarily at individual enrollees. Only Seniors Plus was successful in obtaining substantial numbers of members (one-third of total) through group enrollments.

- All sites developed a minimal marketing effort for Medicaid recipients. Medicaid enrollment was substantially lower than expected.

- The S/HMO marketing budgets were initially inadequate at all sites except KP. Even when marketing resources were increased substantially at SCAN and Seniors Plus, enrollment responses continued to be low.

- S/HMO marketing costs per enrollee were high at all sites (except for KP) and yet they were not high enough to achieve their marketing targets given the many barriers to enrollment.

NOTES

[1] When Medicare was established, HMOs, like other providers, received retrospective cost-based payments from Medicare for Part A and B services, but the payments were made on an interim basis, and were subject to retroactive adjustments by Medicare after detailed cost and utilization reports were submitted by the HMOs (Friedlob and Hadley, 1985). Since a capitated option was not available, HMOs willing to participate in Medicare received fee-for-service payments based on actual costs. Some HMOs offered supplemental coverage to members to cover the costs of coinsurance and deductibles for Medicare coverage (Federal Register, 1985).

In 1972, Section 1876 was added to the Social Security Act. It permitted capitated prepayment to federally qualified HMOs for both Parts A and B and authorized payment to larger HMOs on the basis of "adjusted average per capita cost" (AAPCC) for Medicare beneficiaries in each HMO service area (Federal Register, 1985). Medicare could withhold contract year payments until a retrospective review determined whether the HMO made or lost money on the Medicare contract. If money was lost, the HMO incurred this loss. If profits were made by keeping costs below the AAPCC, the HMO retained half the difference; the rest was returned to the federal government (Federal Register, 1985). The auditing requirements and delayed payment under the program, as well as the limits on the profits that could be kept, discouraged HMO participation. Only one HMO had such a contract by 1984 (Bonanno & Wetle, 1984; U.S. GAO, 1986).

Six HMOs began participating in a Medicare prospective risk capitation demonstration project in 1980. In 1982, as part of a second experiment, 26 more health plans began enrolling Medicare beneficiaries (U.S. GAO, 1986). By June 1984, some 200,000 individuals were enrolled in the Medicare demonstrations (Federal Register, 1985). Evaluations of these plans were conducted by Jurgovan and Blair, Inc., HCFA, and Mathematica Policy Research, Inc. (Galblum & Trieger, 1982; Langwell et al., 1986). The early success of these demonstrations led in part to changes in the federal legislation in 1982.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) authorized fully prospective, capitated payments to HMOs for Medicare beneficiaries without retrospective adjustments (Federal Register, 1985). TEFRA attempted to respond to previous objections of HMOs to the Medicare reimbursement methods. By the time the regulations were finally approved in 1985, many HMOs across the country were ready to sign "risk contracts" with the Health Care Financing Administration (HCFA). Under the rate-setting formula, HMOs with risk contracts (TEFRA) are paid a rate which is 95 percent of the adjusted average per capita cost (AAPCC) rate. If services are estimated to cost less by calculating an adjusted community rate (ACR), the HMO agrees either to use the difference between its adjusted costs to expand benefits or accept the ACR as a reduced monthly payment. The profits for Medicare enrollees are to be no higher

than for the commercial enrollees under 65 years of age (Federal Register, 1985). HMOs may choose to have a cost contract rather than a risk contract, in which HMOs receive per capita prepayments that are later adjusted to reflect actual costs, up to 100 percent of the AAPCC (Iversen, Polich, Dahl, and Secord, 1986). HMOs can also choose to have a Health Care Prepayment Plan (HCPP) contract to provide certain Medicare Part B benefits only. Part A benefits can also be provided by the HMO but not under a contract with HCFA (Iversen et al., 1986).

Until the TEFRA HMO legislation was implemented in February of 1985, HMOs had not actively sought to enroll Medicare beneficiaries for a variety of complex reasons (Bonanno & Wetle, 1984; Titus, 1982). HMOs continued their enrollees who reached retirement age and generally did not attempt to enroll individual Medicare beneficiaries who were not members of their plans before retirement (Titus, 1982). Individuals not in HMOs prior to retirement usually continued with their existing health plans and providers. Consequently, prior to the adoption of the TEFRA legislation, older persons were underrepresented in HMOs (Eve, 1982; Iglehart, 1985; Federal Register, 1986). In 1984, Iversen and Polich (1985a) reported that less that 4 percent of Medicare beneficiaries were enrolled in HMOs and only 35 percent of the HMOs had Medicare beneficiaries enrolled.

The new TEFRA HMOs began operating in Spring of 1985. By June of 1985, there were 183 risk contracts with a total of 968,000 enrollees nationally. The number of enrollees increased to 1.15 million by December of 1985 (Iversen et al., 1986; OHMO, 1986; InterStudy, 1986).

[2] MJGC had a total of 915 nursing home beds, a day hospital, respite care, and other community services (Leutz, Greenberg, Abrahams, Prottas, Diamond, and Gruenberg, 1985, p. 35). MJGC also had sponsored a Nursing Home Without Walls demonstration project in New York to provide community services to Medicaid recipients.

[3] SCAN was originally formed in 1978 to provide community-based long term care services. It later offered these services under contract with the State of California for a Multipurpose Senior Services Program (MSSP) demonstration project. SCAN became a permanent state MSSP site in July of 1983 (Leutz et al., 1985).

[4] Kaiser was an original site in the HMO Medicare demonstration project in August of 1980 and which became a TEFRA HMO in 1985. KP Northwest is a nonprofit HMO with a total enrollment of 286,000 members. In 1985, about 15,000 Kaiser members were in a cost contract, and 11,000 were converted to the TEFRA risk contract. The S/HMO project, like the Medicare HMO demonstration, was sponsored by the Kaiser Health Services Research Center located within KPMCP.

[5] Ebenezer provides comprehensive long term care services in Minneapolis, including 670 nursing home beds, a Medicare-certified home health agency, a homemaker service program, an adult day health care program, advocacy

and support services, and 1,382 congregate housing units. A legal partnership was formed for the S/HMO under the Group Health HMO license (Leutz et al., 1985).

[6] The Elderplan staff model is one that delivered its health services through a physician group controlled by the S/HMO. Their physician group, Geriatric Medical Associates (GMA), was formed for the sole purpose of providing services to Elderplan members and was not allowed to provide services to non-Plan members. The chronic care services were provided under contract by MJGC, the parent corporation.

[7] PGLB was a newly formed independent practice HMO in 1983, based on a group of physicians associated with St. Mary's hospital. PGLB had a contract with SCAN to provide physician services, which were also provided to other HMOs in the area. Hospital services were provided by a contract with St. Mary's hospital, and long term care services were provided through contracts with many different community agencies and organizations.

[8] Group Health, primarily a staff-model HMO, has added some network-model independent group practices. Seniors Plus, however, was designed to use only the Group Health physicians (and not their network physician groups).

[9] KP, originally established as a staff-model HMO, is a group-model HMO that predominately contracts with one independent group practice to provide its services but has some contracts with physician groups. Kaiser provides home-health care services through its own certified agency, and provides nursing home and homemaker services through arrangements with independent community providers.

[10] One of the initial decisions was the geographical area for marketing the plan. Leutz et al. (1985) suggested that the sites considered the following market segment characteristics initially cited by Kotler (1976): (1) sufficient size; (2) a potential for growth; (3) not overoccupied by existing competition; and (4) relative unsatisfied needs. Leutz et al. (1985) states that in considering the initial geographic area for the S/HMOs, two other criteria were used: (1) concentrations of elderly and (2) the cost of providing services to the enrollees.

[11] The data on enrollments reported to HCFA and shown in the tables do not coincide with enrollment data reported by the plans for a number of reasons including delays in data recording. Therefore, the HCFA data is significantly lower than data reported by the plans. For example, Kaiser's Medicare Plus I reported the following enrollment data: 7,500 in April 1985, to 10,026 in December 1985, and to 16,960 enrollees in December 1986. Group Health's Seniors reported enrollment of 4,030 in December 1984 which increased to 6,191 in December of 1985, are to 8,492 in December of 1986). These are both higher than shown in the figures. For data on what the competing TEFRAs reported, see Appendix A-2 through

A-5 in comparison to HCFA data in Appendix A-1.

[12] The initial decision was to do the marketing internally within Group Health for Seniors Plus. A director was hired for marketing in October 1983 and he left in March 1984 due to the uncertainties with the delay in the project. After the director left, the marketing director for Seniors was also made the director for marketing Seniors Plus. In January 1985, an assistant was hired for the marketing director. In July 1985, the marketing director was shifted to another product within Group Health and another director was hired for both senior products strategies and was responsible for the changes in direction in late 1985. By October 1985, that new director left to go to another HMO. In January 1986, a new marketing director was hired for both senior products and directed the marketing effort through the summer of 1987 when this evaluation was conducted.

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TEFRA HMO AND S/HMO[a] ENROLLMENT IN THREE AREAS - 1985-1987

	Jan-1985	Jun-1985	Jan-1986	Jun-1986	Jan-1987	Apr-1987
Portland (Multinomah County)						
Pacificare			1	1,897	3,599	4,658
PHIP			145	801	1,419	1,793
BC/BS		8	478	1,893	3,117	3,169
Kaiser Plus I	3,650	4,258	5,146	5,768	7,177	8,475
Kaiser Plus II[a]		1,752	3,128	4,030	4,221	4,685
Los Angeles						
Pacificare			4,447	7,930	13,030	14,612
Maxicare			4,504	6,834	5,177	4,892
United	4,383	6,293	5,816	8,653	14,364	14,912
FHP	12,590	14,334	21,536	25,619	30,218	31,966
SCAN[a]		525	1,244	1,612	2,038	2,448
Minneapolis/St. Paul						
HMO Minnesota	3,867	4,295	4,584	4,363	4,061	3,925
PHP				16,581	25,302	30,067
Med Centers	8,386	9,642	10,986	12,045	13,146	13,389
SHARE	26,423	28,789	29,246	31,472	34,380	35,762
Senior Health Plan	3,127	4,172	4,333	4,516	2,414	2,449
Group Health Senior	4,287	5,010	5,958	6,471	7,990	8,680
Seniors Plus[a]	13	256	763	1,274	1,797	1,900

SOURCE: Health Care Financing Administration, Office of Health Maintenance Organizations. Unpublished Enrollment Data. Baltimore, MD: HCFA, 1987.

[a] Social Health Maintenance Organization Demonstrations.

HMO MEDICARE ENROLLMENT AND TOTAL MEMBERSHIP
NEW YORK CITY AREA - DECEMBER 1985

HMO	Total Members	Medicare Members	HCPP Contract*	TEFRA Cost	TEFRA Risk	Model Type	Plan Age	Profit Status
Elderplan (Brooklyn)**	776	776	No	0	776	Group	<1	N
Health Insurance Plan (New York)	893,972	78,395	Yes	0	0	Netw.	38	N

SOURCE: Interstudy Center for Aging and Long-Term Care. Improving Health and Long-Term Care for the Elderly: 1986.

* An HCPP contract is a Health Care Prepaid Plan with a contract to provide certain Part B Medicare services. A TEFRA cost HMO is one that uses a cost reimbursement for Medicare payment. A TEFRA risk HMO has a Medicare contract to be paid on the basis of 95% of the adjusted average per capita cost of Medicare in the area.

** Elderplan is a HCFA Social/Health Maintenance Organization Demonstration Project. Interview data. Institute for Health and Aging (IHA). San Francisco, CA: University of California, June, 1986.

HMO MEDICARE ENROLLMENT AND TOTAL MEMBERSHIP
PORTLAND AREA -- DECEMBER 1985

HMO**	Total Members	Medicare Members	HCPP Contract	TEFRA Cost	TEFRA Risk	Model Type	Plan Age	Profit Status
Blue Cross/Blue Shield "First Choice 65+"*	-	4,800	No	0	4,800**	Netw.	-	N
Kaiser Fdn. Health Plan of the NW**	286,342	10,310	No	0	10,310	Group	40	N
PacificCare "Secure Horizons"*	4,000	2,456	No	0	2,456	Netw.	<1	P
Phys. Assn. of Clackamas County (Gladstone)	42,696	8,181	No	8,181	0	IPA	47	N
Physician InterHospital Health Plan*	5,123	198	No	0	198**	IPA	1	N

SOURCE: Interstudy Center for Aging and Long-Term Care. Improving Health and Long-Term Care for the Elderly: 1986.
*Institute for Health & Aging (IHA). Interviews with HMOs. San Francisco: CA: University of California, 1986.

** The Blue Cross/Blue Shield First Choice Plan is a demonstration project that has applied for a risk contract. In June 1986, they reported 4,800 members in the demonstration project and 52,480 with supplemental coverage (IHA data, June 1986). Blue Cross/Blue Shield reported Network Health Plan to Interstudy as an HMO for the elderly but this plan is not reported on this table since it is only for the under 65 enrollees and is not an HMO but rather a product line.

Physician InterHospital Health Plan (PIHP) is also a demonstration project reporting 1,200 Medicare members in June 1986 with a risk contract application pending. They reported 18,000 total members by June 1986 (IHA data, June 1986).

*** Kaiser reported 11,500 in the risk contract and 15,000 remaining in the cost contract (IHA data, June 1986). In the Kaiser risk contract, over 4,000 were enrolled in the HCFA Social Health Maintenance Demonstration project and the remainder were in the risk contract.

HMO MEDICARE ENROLLMENT AND TOTAL MEMBERSHIP
LOS ANGELES AREA* -- DECEMBER 1985

HMO****	Total Members	Medicare Members	HCPP Contract	TEFRA Cost	TEFRA Risk	Model Type	Plan Age	Profit Status
CIGNA Healthplans of California (Glendale)	393,000	10,500	Yes	0	0	Staff	56	P
FHP, Inc.	130,174	32,767	No	0	32,767	Staff	24	P
General Med (Orange)	102,360	1,231	No	1,231	0	Staff	13	P
Health Net of So. California***	308,705	0	No	0	0	IPA	7	N
Inter Valley Health Plan (Pomona)	24,106	902	No	902	0	IPA	6	N
Kaiser Fdn. Health Plan/So. CA Reg. (Pasadena)	1,822,979	127,500	Yes	0	0	Group	40	N
Maxicare - South California	258,502	912	No	912	a	Netw.	12	P
PacifiCare of California (Cypress)	127,417	18,796	No	3,632	13,841	Netw.	7	P
Roos-Loos Health Plan of So. California***	55,013	1,330	Yes	0	0	IPA	7	P
Scan Health Plan**	1,659	1,659	No	0	1,659	IPA	<1	N
United Health Plan (Inglewood)	57,075	6,631	No	0	6,631	Netw.	12	N

SOURCE: Interstudy Center for Aging and Long-Term Care. Improving Health and Long-Term Care for the Elderly: 1986.
*** OHMO. Fiscal Year 1985 Statistical Data for the Type B Federally Qualified HMO Population of the U.S.A. Washington, D.C.: Office of Health Maintenance Organizations, 1985.

* Enrollment figures are for Los Angeles and other surrounding area counties.
** SCAN is a federal HCFA social health maintenance organization demonstration project.
**** In June 1986, FHP reported 1,500 Medicare enrollees remaining in the cost contract, and 33,438 in the risk contract with 1,100 of the risk contract members in the high

option plan. Maxicare reported 10,000 in the risk contrct, PacificCare reported 27,000 in the risk contract and 1,500 remaining in their cost contract, and Health Plan of America reported having just begun marketing with 1,700 in their risk contract in the area. Institute for Health and Aging. Interview Data. San Francisco, CA: University of California, June 1986.

HMO MEDICARE ENROLLMENT AND TOTAL MEMBERSHIP
MINNEAPOLIS/ST. PAUL AREA - DECEMBER 1985

HMO*	Total Members	Medicare Members	HCPP Contract	TEFRA Cost	TEFRA Risk	Model Type	Plan Age	Profit Status
Coordinated Health Care	20,049	25	Yes	0	0	Group	13	N
Group Health	213,245	7,502	No	880	6,622	Netw.	28	N
HMO Minnesota	69,773	16,947	No	0	16,947	Netw.	11	N
MedCenters Health Plan (St. Louis Park)	212,669	12,023	No	0	12,023	Netw.	13	N
Physicians Health Plan of Minnesota (PHP) (Minnetonka)	305,569	48,200	Yes	0	0	IPA	10	N
Senior Health Plan	6,700	4,500	No	0	4,500	IPA	<1	N
SHARE Health Plan (Bloomington)	131,107	35,780	No	0	35,780	Netw.	11	N

SOURCE: Interstudy Center for Aging and Long-Term Care. Improving Health and Long-Term Care for the Elderly: 1986.

* In June, 1986, Group Health reported having 1,358 members enrolled in their federal social health maintenance organization demonstration project and another 7,357 members in their risk contract, out of 213,000 total members. HMO Minnesota reported 11,000 in the risk contract and 6,000 remaining in their cost contract. PHP reported about 25,000 enrolled in their risk contract and 25,000 remaining in their cost contract. Institute for Health and Aging. Interview data. San Francisco, CA: University of California, June 1986.